Physiotherapy in Primary Care

Module 2

Foundations of Team-Based Primary Care

Please note: This course was designed to be interacted and engaged with using the online modules. This **Module Companion Guide** is a resource created to complement the online slides. If there is a discrepancy between this guide and the online module, please refer to the module.

TABLE OF CONTENTS

1.1 THE CORE ELEMENTS OF PRIMARY CARE

Please see the online learning module for the full experience of interactions within this document.

In this section, you will learn about what defines primary care, the core principles of primary care, and why primary care is the foundation for strong health systems.

Learning Objectives

By the end of this section, you will be able to you will be able to define and describe the core elements of primary care. Specifically, you will be able to:

1. Articulate what primary care is and what primary care is not.
2. Identify primary care frameworks and understand the ways in which these frameworks intersect.
3. Describe the impact, benefits, and values of primary care to patients, providers, and health systems.

Defining Primary Care

Primary care and **primary health care** are terms that are often used interchangeably. However the are different - but related. **The focus of this module is primary care.**

Continue to compare definitions of primary health care and primary care as defined by Health Canada (2015).

Primary Health Care

"Primary health care refers to an approach to health and a spectrum of services beyond the traditional health care system. It includes all services that play a part in health, such as income, housing, education, and environment" (Health Canada, 2015).

Primary Care

"Primary care is the element within primary health care that focusses on health care services, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury" (Health Canada, 2015).

The terms primary health care and primary care have also been defined by the World Health Organization (WHO).

Continue to compare definitions of primary health care and primary care as defined by the WHO.

Primary Health Care

"Primary health care (PHC) is a broader whole-of-society approach with three components: (a) primary care and essential public health functions as a core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities." (World Health Organization, n.d.)

Primary Care

"Primary care is a key process in a health system that provides promotive, protective, preventive, curative, rehabilitative, and palliative services throughout the life course." (World Health Organization, n.d.)

The Four "Cs" of Primary Care

Barbara Starfield , an American physician described four core attributes (sometimes referred to pillars or elements) of primary care (Starfield et al., 2005).

1. **First contact access** and use: Primary care is the place where most people enter the health care system whenever it is necessary.
2. **Continuous**: The long-term relationships between a person and a health professional or a team of providers built on mutual trust forms the foundation of primary care.
3. **Comprehensiveness**: A diverse range of health promotion, prevention, protection, treatment, rehabilitation, and palliative services are provided appropriate to the primary care context.
4. **Coordination**: Services and care received across the health systems is organized and integrated over time.

Note: A fifth element, **patient- or person-centred**, has been added that focuses on the need to educate and empower people need to make decisions and participate in their own care.

Recommended Reading

Continue to read more about the four core attributes of primary care in Starfield's paper **Contribution of Primary Care to Health Systems and Health**.

Building on Starfield

Next, you will learn about three other projects that build on Starfield's four core attributes of primary care and how the elements of primary care may be operationalized.

1. The 10 Building Blocks

In 2014 Thomas Bodenheimer published 10 building blocks of high-performing primary care. The development of these building blocks was informed by case study research including site visits to 23 practices and a review of the literature on models of primary care (Bodenheimer, 2014).

Continue to learn about the 10 building blocks of high-performing primary care.

1. **Leadership**

Fully engaged leaders at all levels of the organization, who are fully engaged in the process of change.

2. **Data Driven**

Data systems that track clinical, process, and patient experience metrics that are regularly shared to foster improvement.

3. **Empanelment**

Patients are linked to a primary care team and primary care clinician. This enables monitoring of panel size, care needs, adjusting workload, and supporting population management.

4. **Team-Based Care**

Teams have a varied composition, with key features to support collaboration including co-location, respect, strategies for regular communication, and empowering each team member.

5. **Patient**

Patient-team partnership means that patients are engaged in shared decision making.

6. **Population Management**

Primary care practices stratify the needs of their patients to provide care and team members that match their needs.

7. **Continuity of Care**

Each patient is linked to a primary care provider and team (requires empanelment).

8. **Prompt Access**

Prompt access to care is linked to measurement and control of panel size and a high functioning team.

9. **Comprehensiveness and Care Coord**

Comprehensiveness refers to the ability of the practice to provide most of what a patient needs. Care coordination refers to the responsibility of the provider to coordinate/arrange services that primary care is unable to provide.

10. **Template of the Future**

A clinic that offers a variety of forms of interactions including virtual, in-person, individual, group, and visits with team members. Payment models are needed that don't reward in-person visits.

Recommended Reading

Continue to read more about the 10 building blocks of high-performing primary care.

2. Shared Principles of Primary Care

Ted Epperly led a collaborative multi-stakeholder process to define the principles of primary care to provide a shared language and common voice. The conceptual model was developed in response to criticisms of past models that have been seen as 'physician directed' and described as 'patient-centred' without including strong community voices in the creation of the principles (Epperly et al., 2019).

"The collaborative process reidentified the four classic Starfield principles—continuous, comprehensive, coordinated, and accessible—along with several other important concepts." (Epperly et al., 2019)

Continue to learn about the shared principles of primary care determined through Epperly's collaborative process.

Person- and Family-Centred

Shifting from patient- to person-centred, the first principle seeks to develop "an empowered partnership role for individuals and families" where care is individualized and based on strengths, values, and goals using shared decision making (Epperly et al., 2019).

Continuous

This principle reiterates the relational foundation of primary care as a "dynamic, trusted, respectful, and enduring relationship[s] between individuals, families, and their clinical team members" (Epperly et al., 2019).

Comprehensive and Equitable

This principle calls primary care to consider the impact of social determinants and societal inequities and to serve all ages, genders, and the broadest of health care issues. Under this principle primary care is called upon to partner with community-based organizations to promote population health and health equity.

Team-Based and Collaborative

Primary care recognizes the interprofessional nature of practice, where health professionals work to the top of their skills and where each is valued and workload distributed to ensure a healthy workforce.

Coordinated and Integrate

In this principle, coordinated refers to how health care is organized and arranged beyond primary care. Integrated considers how health data and records may inform care both in primary care and within the broader health "neighbourhood."

Accessible

This principle considers the many ways individuals can access primary care including both in-person and virtually (phone/video/other) and removes any physical, cognitive, socioeconomic, literature, and linguistic barriers. It also supports people's access to their own health information.

High Value

This principle asserts primary care is responsible for both health outcomes and the judicious and responsible use of health care resources.

Recommended Reading

Continue to read more about the shared principles of primary care as described by Epperly.

3. The Patient's Medical Home (PMH)

In 2011 the College of Family Physicians of Canada released **A Vision for Canada: Family Practice – The Patient's Medical Home**, which included 10 pillars of practice. This document was revised in 2019 providing clear definitions for attributes within the 10 pillars along with supporting research.

"The PMH is a family practice defined by its patients as the place they feel most comfortable presenting and discussing their personal and family health and medical concerns. The PMH can be broken down into three themes: Foundations, Functions, and Ongoing Development" (College of Family Physicians of Canada, 2020).

Continue to learn about the different pillars of practice as described by the PMH Vision Document.

1. **Pillar 1: Administration and Funding**

"Practices need staff and financial support, advocacy, governance, leadership, and management in order to function as part of the community and deliver exceptional care."

2. **Pillar 2: Appropriate Infrastructure**

"Physical space, staffing, electronic records and other digital supports, equipment, and virtual networks facilitate the delivery of timely, accessible, and comprehensive care."

3. **Pillar 3: Connected Care**

"Practice integration with other care settings and services, a process enabled by integrating health information technology"

4. **Pillar 4: Accessible Care**

"By adopting advanced and timely access, virtual access, and team-based approaches, accessible care ensures that patients can be seen quickly."

5. **Pillar 5: Community Adaptiveness and Social Accountability**

"A PMH is accountable to its community, and meets their needs through interventions at the patient, practice, community, and policy level."

6. **Pillar 6: Comprehensive Team-Based Care with Family Physician Leadership**

"A broad range of services is offered by an interprofessional team. The patient does not always see their family physician but interactions with all team members are communicated efficiently within a PMH. The team might not be co-located but the patient is always seen by a professional with relevant skills who can connect with a physician (ideally the patient's own personal physician) as necessary."

7. **Pillar 7: Continuity of Care**

"Patients live healthier, fuller lives when they receive care from a responsible provider who journeys with them and knows how their health changes over time."

8. **Pillar 8: Patient- and Family-Partnered Care**

"Family practices respond to the unique needs of patients and their families within the context of their environment."

9. **Pillar 9: Measurement, Continuous Quality Improvement, and Research**

"Family practices strive for progress through performance measurement and CQI. Patient safety is always a focus, and new ideas are brought to the fore through patient engagement in QI and research activities."

10. **Pillar 10: Training, Education, and Continuing Professional Development**

"Emphasis on training and education ensures that the knowledge and expertise of family physicians can be shared with the broader health care community, and also over time by creating learning organizations where both students and fully practising family physicians can stay at the forefront of best practice."

Recommended Reading

Continue to read more about the PMH's vision.

How do the concepts compare across these three descriptions of primary care foundations?

A summary table of the different characteristics of the three frameworks of primary care presented in this section is provided for you.

Key Concepts	**10 Building Blocks**	**Shared Principles of Primary Care**	**Patients Medical Home**
Development of Framework	Case studies of primary care sites, literature review	Broad stakeholder engagement including people and families	College of Family Physicians of Canada
Starfield's 4 C's	Empanelment Comprehensiveness Care coordination	Coordinated and integrated Comprehensive and equitable Continuous	Comprehensive team-based care Continuity of care Connected care
Patient – Families	Patients engaged in shared decision making	Person- and family-centred, "empowered partnership"	Patients and family partnered care
Team-based	Collaboration and empowerment of team members	Team-based and collaborative, supporting working to full skill set	Team-based care with physician leadership
Equity		Comprehensive and equitable	
Access	Prompt access to care	Accessible	Accessible care

Continue to understand the benefits of defining the core principles or attributes of primary care.

Benefits of Defining Principles of Primary Care

- Primary care practices and providers can consider how their current practice is consistent with the principles and where they may need further work.

- Educators can focus interprofessional education on team-based primary care and encourage broader professions (e.g., social work, physical therapy, occupational therapy, pharmacy, dietitians, nursing, psychology) to consider how these principles can be incorporated and aligned within their current training.
- Governments of all levels can be encouraged to consider how funding models, governance structures, and reforms foster these principles.
- Interprofessional practitioners can develop a common language and understanding of primary care to better conceptualize, articulate, and implement their full skills set in primary care teams.

Primary Care: What it is Not

Primary care takes place in the community but does not include any/all care in the community.

Continue for four examples of care in the community outside of primary care.

Home Care Services

Home care services support people to remain in their homes and provide targeted care by a range of providers. While community-oriented, it does not offer care for all health issues and does not coordinate additional care outside of what is provided within the bundle of allowed and designated home care services.

Outpatient Services

Outpatient services are typically attached to a hospital, rehabilitation centre, or clinic. These services are typically time-limited.

Primary Health Care

Primary health care encompasses a broader suite of supports to support the overall health of people, communities, and populations and may include housing, food, or education. This term is quite often used interchangeably with primary care, however by definition goes beyond the health system.

Hospitals

Hospitals provide institutional based care.

Complete the activity by selecting and dragging the example service into the correct category (primary care, primary health care, or other).

Options: Outpatient Pain Clinic at the Ottawa Hospital, A Community Health Centre in Halifax, Sunnyhill Long Term Care, Emergency Department in Grand Prairie, Foodbank in Grand Prairie, Social housing in Vancouver, A Family Health Team in Ontario, A "My Health Team" in Manitoba

Feedback:

Correct Responses:

- Primary Care
- A Community Health Centre in Halifax

- Sunnyhill Long Term Care
- A Family Health Team in Ontario
- A "My Health Team" in Manitoba

Primary Health Care

- Foodbank in Grand Prairie
- Social housing in Vancouver

Other

- Outpatient Pain Clinic at the Ottawa Hospital
- Emergency Department in Grand Prarie

Defining High Quality Primary Care

Now that you have an understanding of the core elements of primary care, it is important to define what high quality primary care looks like in practice.

"**High quality primary care is the foundation of a high functioning health care system and is critical for achieving health care's quadruple aim**" (National Academies of Sciences, Engineering, and Medicine, 2021).

Moreover, **high quality primary care is** "the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities" (National Academies of Sciences, Engineering, and Medicine, 2021).

High quality primary care is associated with health care that is more efficient, more effective and patient-centred, and has fewer inequities and more inclusive communities.

Continue for research findings supporting high quality primary care.

MORE EFFICIENT

Widespread research across countries has shown that high performing primary care systems have lower overall health expenditures with reductions in unnecessary procedures and avoidable use of emergency departments and hospitals. This is achieved through prevention, early identification, and the long-term relationships established in primary care (OECD, 2020).

MORE EFFECTIVE AND PATIENT CENTRED

Research from across the globe has shown that high quality primary care can improve population health outcomes and create more patient-centred care. Seminal research by Starfield, Shi, and Macinko (2005) explored the contribution of primary health care on health in 18 OECD countries finding that the greater a country's orientation to primary health care, the better the population health outcomes.

Further examples can be found in the **OECD Policy Brief**(opens in a new tab)

FEWER INEQUITIES AND MORE INCLUSIVE COMMUNITIES

Primary care providers and teams are ideally situated to address health inequities with the core tenants of primary care focusing directly on addressing health equity and community needs. Studies have shown, that strong primary health care, as the first point of contact with the system, leads to better access and more equitable and overall better quality of care.

Primary care offers effective health promotion and prevention, addressing health and social determinants through long-term relational and comprehensive care.

Details examples can be found in the **OECD Policy Brief**(opens in a new tab)

Recommended Readings

Continue for more information and examples of high quality primary care.

OECD Health Policy Studies

Realising the Potential of Primary Health Care

Contribution of Primary Care to Health Systems and Health

Building High-Performing Primary Care Systems:

After a Decade of Policy Change, Is Canada "Walking the Talk?"

Quadruple Aim

The Quadruple Aim (originally the Triple Aim) introduced by the Institute of Healthcare Improvement is considered the 'north star' of a health system. As the name indicates, it is centred around four goals:

1. Improve the health of populations
2. Enhance patient experience
3. Reduce health care costs
4. Ensure workforce wellness

Note: Equity - A Proposed Quintuple Aim

The COVID-19 pandemic brought much attention to issues of health equity and a fifth aim has been proposed.

Recommended Readings

Continue for more information on the Triple, Quadruple, and Quintuple Aim.

The Triple Aim Journey:

Improving Population Health and Patients' Experience of Care, While Reducing Costs

From Triple to Quadruple Aim:

Care of the Patient Requires Care of the Provider

The Quintuple Aim for Health Care Improvement

A New Imperative to Advance Health Equity

In this section, you learned about the core principles or attributes of primary care and how these contribute to higher quality and more efficient health systems. In the next section, you will learn about different models of primary care from across Canada.

Continue to Section 1.2

Page link:

https://doi.org/10.1111/j.1468-0009.2005.00409.x

https://doi.org/10.1370/afm.1616

https://journals.stfm.org/familymedicine/2019/february/epperly-2018-0288/

https://patientsmedicalhome.ca/vision/

https://www.oecd-ilibrary.org/social-issues-migration-health/realising-the-potential-of-primary-health-care_a92adee4-en

https://www.oecd-ilibrary.org/social-issues-migration-health/realising-the-potential-of-primary-health-care_a92adee4-en

https://doi.org/10.1787/a92adee4-en

https://doi.org/10.1111/j.1468-0009.2005.00409.x

https://doi.org/10.1111/1468-0009.12674

https://www.commonwealthfund.org/publications/case-study/2010/jul/triple-aim-journey-improving-population-health-and-patients

https://doi.org/10.1370/afm.1713

https://jamanetwork.com/journals/jama/article-abstract/2788483?casa_token=_wvXs-YA0doAAAAA:NHGnnxoOaN9bmVd3HK82XP9hFPdq2Zr4KBBmK_uGJSuJ0u039dQqRE3dbmO8l55tyxC4W7zO0NU

1.2 MODELS OF PRIMARY CARE

Models of care describe the way care health services are organized and delivered. In this section, you will learn about the historical context of primary care in Canada and how that influences the models of care we see today. You will further learn about different models of care delivery from across Canada and the extent to which they include the patient voice, population health approach, and geographical orientation.

Learning Objectives

By the end of this section, you will be able to describe commonly used models of primary care in Canada. More specifically you will be able to:

1. Recognize the historical context of primary care in Canada and how this relates to the current state of practice and current challenges.
2. Describe examples of team-based primary care models from across Canada.
3. Describe how the patient's voice is included in different practice models.
4. Identify how practice models incorporate a population focus and geographical orientation to support equitable access.

"Successful achievement of the four core functions of [primary care] (the "4Cs") is linked to improved population health, more appropriate use of healthcare resources and reduced costs and more generally to better-functioning health systems" (Jeminez et al., 2021)

"Access to health care based on need rather than ability to pay was the founding principle of the Canadian health-care system" (Martin et al., 2018).

To understand the current structure of primary care it is important to understand the history of our publicly funded health care system – Medicare.

There are a few key points to note that have laid the foundation for primary care system:

1. In order for Medicare to be passed, physicians negotiated the maintenance of their fee-for-service renumeration, clinical autonomy, and control over the location and organization of their medical practices. These three factors heavily influence the delivery of primary care today.
2. Medicare's origins are hospital based. While 70% of health services in Canada are funded under Medicare, 30% are covered by private insurance or out-of-pocket payments. Many of the interprofessional team members would only be free for Canadians while in hospital-based care or home care. Those Canadians who are rostered to primary care teams have significantly enhanced access to free healthcare services - raising issues of equity.

Recommended Readings

Continue to learn more about Canada's publicly funded health care system.

Canada's universal health-care system: Achieving its potential

Canada: Health System Review

Primary Care Reforms

Having an idea of where we have come from in terms of health care in Canada will help us understand where we are going and visualize where we hope to be going. The information in the following timeline was sourced from Lukey et al. (2021) and Donnelly et al. (2023).

- ***1980s-1990s***

Early Primary Care Reform

This was known as a time of stagnation. Primary health care reform in Canada was characterized by small-scale pilot projects. Attempts to advocate for system change failed, with minimal changes occurring. The were limited innovations in organizational, funding, or delivery of primary care.

- ***Early 2000s***

Investment in Primary Care

The Primary Care Transition Fund was an 800 million dollar investment in primary care reform. In 2003, the First Ministers Accord invested another 16 billion in health reform, with primary care being a major focus.

In 2004, the First Ministers set a goal that 50% of Canadians would have 24/7 access to an interprofessional primary care team by 2011. This clearly has not been met, but change was occurring which set in motion a focus on team-based primary care.

- ***Mid-2000s***

Investment in Team-Based Primary Care

While the goals of reforms differed across provinces, there were similar themes related to:

- Improved access to primary care services;
- Better coordination and integration of care;
- Expansion of team-based care;
- Improved quality/appropriateness of care, with a focus on prevention and the management of chronic and complex illness;
- Greater emphasis on patient engagement/self-management and self-care; and
- The implementation and use of electronic medical records and information management systems (Hutchinson et al., 2011).

Across the country a handful of provinces were investing in primary care teams including Alberta, Manitoba, Ontario, and Quebec.

- ***2015+***

Integrated Care

Moving into the 2020s, there has been a renewed interest in team-based primary care because of the growing health human resource and primary care crisis leading to larger numbers of Canadians who

are without a primary care provider. Most provinces have a model of team-based primary care (as described later in this section). Others, like Ontario for example, have invested further to enhance access to teams.

Alongside the emphasis on primary care teams, there has been an increased focus on models of integrated care, where primary care plays a central role in supporting a more integrated health system.

Recommended Reading

Continue to learn more about the reformation of primary health care in Canada.

Patient's Medical Home (PMH)

Recall that the Patient's Medical Home (first introduced in **Section 1.1 The Core Elements of Primary Care**) has been the vision for the future of primary care in Canada. One of the pillars of the PMH is team-based care, but there are differences in how this has been enacted or planned across provincial, territorial, and National health systems in Canada. This has led to differential access to team members.

Continue for examples of how the different provinces have enacted team-based care. Note that these examples were sourced from the PMH Vision document.

British Columbia: Primary Care Networks

Practice examples in British Columbia(opens in a new tab)

In 2018, the provincial government announced the launch of a primary health care strategy with team-based care as the overarching principle and the PMH vision serving as the basis for Primary Care Networks (PCNs), which knit together services and organizations to better coordinate care for patients. As of 2022, 43 PCNs have been established across the province and six PCNs are in the final stages of planning.

Alberta: Primary Care Networks

Practice examples in Alberta(opens in a new tab)

From local family practices to their supporting Primary Care Networks (PCNs), Alberta continues to work toward PMH initiatives and primary care reform, as outlined in its Primary Health Care Strategy. In Alberta, PCNs link groups of family physicians and other health care professionals, who work together to provide care specific to community/population needs.

Saskatchewan: Health Networks

Practice examples in Saskatchewan(opens in a new tab)

Following a recommendation by the Saskatchewan Advisory Panel in 2016, the Government of Saskatchewan decided to develop team-based primary health care in Saskatchewan in the form of Health Networks.

Health Networks connect patients to teams of primary health care professionals and community partners. These primary care teams may include physicians, nurses, pharmacists, physiotherapists, dietitians, mental health counsellors, social workers, and other professionals.

Manitoba: My Health Homes

(opens in a new tab)Practice examples in Manitoba(opens in a new tab)

Following the government's pledge in 2015 to provide every Manitoban with access to a family doctor, Manitoba has continued to implement its Primary Care Strategy that includes team-based care initiatives such as the PMH-inspired My Health Teams (MyHTs) and Home Clinics.

Manitoba's MyHTs bring together various health care professionals to provide coordinated, continuous, accessible, and high-quality care to the populations they serve. Most MyHTs are comprised of doctors, nurses, nurse practitioners, and other health care professionals such as dietitians, pharmacists, mental health workers, social workers, spiritual care providers, community developers, exercise specialists, physiotherapists, and occupational therapists. These health care professionals leverage one another's expertise and skills to provide the best possible care for patients, including patients with chronic conditions.

Ontario: Family Health Care Team (FHT)

Practice examples in Ontario(opens in a new tab)

The Government of Ontario has taken steps in recent years to implement a variety of primary care models that align with the principles of the PMH.

Family Health Teams (FHTs) align with the PMH vision in that they comprise of a multidisciplinary team of health care workers including family physicians, nurse practitioners, social workers, dietitians, and other health care professionals who work together to provide community-centred primary care programs and services.

Quebec: Groupes de medecine de famille (GMF)

(opens in a new tab)Practice examples in Quebec(opens in a new tab)

In 2009, a merger of Groupes de médecine de famille (GMF, family medicine groups) and traditional network clinics resulted in rostering patients to newly formed multidisciplinary teams. Currently in Quebec there are three types of team-based care clinics:

1. Groupe de médecine de famille (GMF) is a group of doctors that works in collaboration with other health and social services professionals such as nurses or social workers. Patients seeking care at a GMF can receive medical services from their own family physician, from another family physician in the group, or from a nurse practitioner if their family physician is not available. Services can also be provided from any professionals of the GMF. To help promote quick access to primary care, all doctors affiliated with the same GMF have full access to the medical records of registered patients.

2. Groupe de médecine de famille universitaire (GMF-U; family medicine teaching unit) also offers team-based care from a range of health care professionals. In addition they serve as sites of education and training, mostly for residents but also for medical students and interns of other professions. GMF-Us are also staffed by doctors and other qualified professionals who see patients as needed.
3. Groupe de médecine de famille – réseau (GMF-R), also known as a super clinic, is a group of family doctors who work together and in close collaboration with other health professionals, such as nurses, to meet semi-urgent or simple urgent needs. The GMF-Rs are accessible to non-registered patients.

New Brunswick: Family Health Team

Practices examples in New Brunswick(opens in a new tab)

In March 2011, the Primary Health Care Advisory Committee (working committee established by the Minister of Health) released the committee's discussion paper: **Improving Access and Delivery of Primary Health Care Services in New Brunswick** with the recommendation that all New Brunswickers will have access to a family practice team that is able to provide them with personalized, comprehensive, and coordinated primary health care services. In November 2012, the first Family Health Team (FHT) was officially launched in Miramichi.

FHTs have been defined as: locally driven, family health-care delivery organizations that include family physicians, nurse practitioners, nurses, and a broad range of other interdisciplinary health-care providers, working together collaboratively to provide comprehensive, accessible, and coordinated family health-care services to a defined population, which includes patients who do not currently have a family health-care provider.

Nova Scotia: Collaborative Family Practice Team

Practice examples in Nova Scotia(opens in a new tab)

In Nova Scotia, there are 96 Collaborative Family Practice Teams, a group of health care providers who provide responsive, patient-centred, comprehensive, and accessible primary care. The teams can consist of family doctors, nurse practitioners, registered nurses, social workers, dietitians, and other health professionals.

Supported by the Nova Scotia Health Authority through the provincial government, Collaborative Family Practice Teams work within a Health Home model, a patient-centred, team-based, primary health care delivery system that promotes access to timely, coordinated, comprehensive, and continuous primary care with the potential to ease the workloads of family physicians, improve doctor retention, and allow better access to care.

Prince Edward Island: Patient Medical Home

Practice examples in Prince Edward Island(opens in a new tab)

In the spring of 2022, the PMH model was established at five primary care locations, beginning the shift to collaborative team-based care for Islanders. Developed and endorsed by the College of Family

Physicians of Canada™, the PMH model leverages the skills and experience of a physician-led team of health care professionals working collaboratively to deliver comprehensive care for patients. This shift in primary care philosophy will allow Islanders attached to PMH to benefit from greater access to comprehensive health care.

These established PMHs will continue to add team members as the nurses, physicians, and allied health care providers develop their practices. As teams mature, build their capacity, and add other health care professionals, new patients will be accepted. Additional practices across PEI are at various stages of embracing the team-based model of primary care with plans for the establishment of more PMHs in the future.

People and Family as Partners

Recall that one of the shared principles of primary care was 'Person or Family Centred.' As described by Epperly et al.(2019), person- and family-centred primary care focuses on the whole person, is grounded in mutually beneficial partnerships that make patients and health professionals equal partners within the primary care team, customization of care through shared decision-making, and opportunities for individuals and their families to shape the design, operation, and evaluation of primary care delivery.

Continue to learn about the role of including people and family as partners in shared decision making and improving care.

SHARED DECISION MAKING

Each of the frameworks in **Section 1.1 The Core Elements of Primary Care** includes a focus on the patient, family, and community with an emphasis on empowering people and engaging in shared decision making. At the level of patient-provider interaction, shared decision making tools are available that can help support primary care providers.

*Continue to view an **inventory of shared decision making tools**(opens in a new tab).*

IMPROVING CARE

At the level of the system, research has shown that including the perspectives of patients and families in the design and delivery of primary care can improve care. There is a continuum of engagement with patients with different approaches depending on the depth, from one way sharing to collaborative partnerships. Tools such as the Public and Patient Engagement Evaluation Tool (PPEET) can help to guide the process.

*Continue to view the **Public and Patient Engagement Evaluation Tool (PPEET)(opens in a new tab).***

Methods for Engaging Patients

Actualizing the principle of person- and family-centred care by engaging patients and families in the design, planning, implementation, and evaluation of primary care can be challenging. In **Figure 3**, Kiran et al. (2020) describe how increasing levels of engagement on the continuum of engagement requires increasing effort, but with potentially greater benefits in terms of the extent to which the principle of person- and family-centredness is achieved. Across all of the models of care described in this section, there is significant variance in the extent to which patients are engaged currently, with some models

having community-based governance models in which patients and families are equal partners, others having patients and families serving advisory roles, and some that have yet to implement patients within planning and operation activities.

Population Health

It has been said that one of the key issues to managing chronic disease in primary care is ensuring the right services are directed to the appropriate individuals, at the right time. Wallace and Siedman (2007) described three groups of clients in primary care, which are frequently presented in the Kaiser Permanente Population Health Risk Pyramid.

Continue to learn about the three groups of clients in primary care as described by Wallace and Siedman (2007).

People Who Are Well

The first group (people who are well) includes individuals who have little interaction with the health care system and who, with the right supports, can effectively manage their own health. This first group is said to account for approximately 70% of the individuals in primary care and would most benefit from self-management approaches.

People With Chronic Conditions

The second group (people with chronic conditions) comprises approximately 20% of a primary care caseload and includes individuals who have one or more chronic conditions and are at risk of further decline. Targeted team-based approaches and chronic disease management are best suited for this intermediate second group.

People With Complex Health Needs

The third and final group (people with complex health needs) represents a small portion of individuals, approximately 5% of the total caseload, who have multiple chronic conditions and complex needs and who would benefit from a higher intensity case management approach.

It has been shown in multiple jurisdictions in Canada that individuals in this last group of primary care clients have the highest health care use and account for the majority (upwards of 60%) of total health care costs (Public Health Agency of Canada, 2017). Many of the people in this group have physical, cognitive, and emotional health needs, increasing the complexity of services.

The Population Health Risk Pyramid depicted in this module is modified from the Kaiser Permanente pyramid and describes the occupational therapy role in primary care with different populations at various levels.

In this section, you learned about the historical context of primary care in Canada, different models of team-based primary care across Canada, and strategies for engaging patients and families in primary care teams. In the next section, you will learn about advancing culturally safer, equity-oriented primary care.

Continue to Section 1.3

Page links:

https://doi.org/10.1016/S0140-6736(18)30181-8

https://pubmed.ncbi.nlm.nih.gov/33527903/

https://doi.org/10.1111/j.1468-0009.2011.00628.x

https://patientsmedicalhome.ca/pmh-in-canada/pmh-british-columbia/

https://patientsmedicalhome.ca/pmh-in-canada/pmh-alberta/

https://patientsmedicalhome.ca/pmh-in-canada/pmh-saskatchewan/

https://patientsmedicalhome.ca/pmh-in-canada/pmh-manitoba/

https://patientsmedicalhome.ca/pmh-in-canada/pmh-ontario/

https://patientsmedicalhome.ca/pmh-in-canada/pmh-quebec/

https://patientsmedicalhome.ca/pmh-in-canada/pmh-new-brunswick/

https://patientsmedicalhome.ca/pmh-in-canada/pmh-nova-scotia/

https://patientsmedicalhome.ca/pmh-in-canada/pmh-prince-edward-island/

https://www.decision.chaire.fmed.ulaval.ca/outils-en

https://ppe.mcmaster.ca/resources/public-and-patient-engagement-evaluation-tool/

1.3 ADVANCING CULTURALLY SAFER, EQUITY-ORIENTED PRIMARY CARE

Thank you for taking the time to learn more about how to **promote culturally safer and equity-oriented primary care**. Before we begin, we want to acknowledge that the learning objectives for this chapter were co-developed by interprofessional healthcare professionals with the understanding that this is work we all need to do to ensure a more just, equitable future. The content for this section was designed, curated, and reviewed by a small team of healthcare professionals, and includes words of wisdom from an Elder in Northern Ontario.

This section is meant to be used as an opportunity to learn, discuss, and reflect with an open mind and heart about your own positionality, and your ability to practice culturally safer and equity-oriented primary care. In this work we want you to especially consider how power and privilege can impact the ways in which you foster relationships and provide primary care. We hope through this section you will find additional opportunities to reflect not only on your own practice, but on your team and the larger role of primary care within our health system to promote healthy equity. The content in this section is not exhaustive and should be viewed as one entry point into this work. We recognize the journey towards cultural safety, health-equity, and just healthcare systems is ever evolving and growing, and that new resources are being produced to further this work even as this is created.

Learning Objectives

By the end of this section, you will be able to:

1. Define components of culturally safer, equity-oriented primary care.
2. Recognize how social determinants of health impact the needs, access, and the provision of primary 3
3. Utilize an IDEA (Inclusion, Diversity, Equity, Accessibility) lens to identify strategies to promote accessibility and equity in primary care practice.

"Equity-oriented health care is about directing adequate resources to those with the greatest needs" (EQUIP Health Care, 2024).

Advancing Culturally Safe, Equity-Oriented Primary Care

To be able to advance cultural safe and equity-oriented primary care it is important to have a shared understanding of key components of this approach. For the purposes of this module, we will focus primarily on cultural safety, cultural humility, and health equity. We will also connect these concepts within a larger narrative that acknowledges the ways in which power, privilege, positionality, and structural systems of oppression impact team-based primary care practice.

Cultural safety is what is **felt** or **experienced** by a person when a healthcare provider communicates with the person in a **respectful, inclusive way**. This **empowers the person** in decision making and **builds a healthcare relationship** in which the person and provider **work together as a team** to ensure maximum effectiveness of care (Jull & Giles, 2012; NAHO, 2008).

Culturally safe practice involves acknowledging that healthcare providers hold a position of power in therapeutic relationships (COTO, n.d.; NAHO, 2008). This approach also acknowledges that as a result

of historical and ongoing mistreatment within healthcare systems, individuals from equity-deserving groups may never feel safe in these spaces (Gerlach, 2012). Healthcare professionals in primary care must continuously work toward practicing in culturally safer ways, ways that show respect of culture and identity, are free of discrimination and incorporate the rights and unique needs of the individual seeking care.

Note: While ultimately the individual receiving services determines what they consider to be safe, healthcare professionals can commit to learning about the historical and ongoing social and political contexts that affect people's experiences with health, healthcare, well-being, and healthcare professionals (COTO, n.d.).

Trauma-Informed Approaches

Healthcare professionals working in team-based primary care should have a basic understanding of the prevalence of trauma and its potential effects on the people and communities they work with. Research demonstrates that individuals of equity-deserving groups are more likely to experience both interpersonal and systemic trauma and violence (COTO, n.d.; Klinic, 2013). This can affect the services they require and receive, and primary care professionals need to know how to properly manage client trauma experiences and responses.

The five guiding principles of a trauma-informed approach include:

1. Safety,
2. Choice,
3. Collaboration,
4. Trustworthiness, and
5. Empowerment (Klinic, 2013; Van der Kolk, 2015).

We encourage learners to explore trauma-informed care approaches as part of their professional development towards enacting culturally safe, equity-oriented primary care practice.

WORDS OF WISDOM

"Patients should be active participants in primary care, rather than coming in, presenting your health card, sitting down… like robots. It's so passive. How can we bring your unique imprint (you and your story) into your care plan/journey?"

- Elder Kerry McLaughlin, Thunder Bay, ON

Cultural Humility

Cultural humility is the dynamic process of self-awareness, self-reflection, and identification of how our assumptions and biases may be aligned with dominant cultural narratives (Agner, 2020; Alsharif, 2012). Cultural humility encourages a dialogical approach that notices, recognizes, and responds to different viewpoints while considering systemic pressures and issues (Agner, 2020; Beagan, 2015). Within primary care, this could look like a healthcare professional identifying their own **unconscious and conscious bias** and reflecting on the ways in which these influence how they form relationships and practice, both within their team and with their patients.

Recommended Resources

Continue to view some recommended resources to explore cultural safety more deeply.

Project Implicit

Practical tools and support for understanding and identifying unconscious and conscious bias.

Cultural Safety Design Collaborative

Healthcare Excellence Canada

A Conceptual Framework for Indigenous Cultural Safety Measurement

National Collaborating Centre for Indigenous Health

Cultural Humility: A Concept Analysis

Reflective Practice Questions

The following reflective practice questions were developed by the College of Occupational Therapist of Ontario and can be used to help you explore cultural safety and humility in your primary care practice (n.d.). You are welcome to reflect on any or all of them as part of your or your interprofessional teams' professional development.

Continue to reveal the back containing things to consider for each reflection question. Continue to navigate to the next reflection question.

Who is likely to feel welcome in my practice setting?

Do the values, philosophies, and goals of my practice setting align with those of the current population that I am providing service to?

Things to consider: What does the space look like as soon as someone walks in? How are they greeted? Is there a space for people to talk in confidence at the front?

Setting the tone for the experience is very important during the initial impression.

How do I determine whether my clients feel welcomed, valued, safe, and comfortable?

Things to consider: Body language and non-verbal cues, nature of conversation (one word answers vs more robust responses), do they make a follow up appointment and ask specifically to see a certain person?

What can I do: Hold space. Don't rush the conversation. Take time to listen. Don't stand in between the person and the door, give them an opportunity to leave if they feel they need to. Try to focus on the conversation and not taking notes. Create a genuine interaction of wanting to learn more and how you might be able to offer support.

In what ways do I create ethical spaces in my practice?

How can I use ethical spaces to better understand my client as a person, including their unique social location, worldviews, beliefs, and values?

What can I do: Introduce yourself as a person first. Not your title. Position yourself so you are even with the client (both sitting) rather than standing over them. Learn about them. What do they find meaningful. What do they enjoy? Take a strengths-based approach instead of focusing on challenges.

What barriers exist to accessing the services I/we provide? Are there cultural, economic, physical, political, or social obstacles that should be addressed?

How can we help to make available services more accessible?

Things to consider: Are there certain days/times that won't work for appointments due to cultural practices (e.g., moontime, fasting)? Are there economic barriers to accessing services (e.g., transportation and parking costs)? Are there physical barriers to reaching service locations (e.g., long walk from the parking lot)? Does the client feel uncomfortable coming to the clinic? How are clients discussed in rounds? Do policies and procedures exist to promote a safe workplace culture? Is there a whistleblowing policy? Who holds people accountable? What kinds of training and education exist for our team?

What can I do: Learn about the client.

Based on my own experiences, do I feel culturally safe at work? Have I experienced discrimination, inequity, or oppression because of my social identities?

Things to consider: Your own safety and wellbeing. Think about a plan to manage these experiences if they occur with my clients, or with my team.

Adopting a Health Equity-Orientation

Health is a fundamental human right (Ghebreyesus, 2017).

Canada may be one of the healthiest countries in the world however, some Canadians are healthier than others and importantly, not all Canadians have equal opportunities to be healthy (Government of Canada, 2024). These **differences in health status among individuals and groups are health inequalities**. Health inequalities exist as a result of the dynamic interplay of our genes and our life choices (Government of Canada, 2024; WHO, 2021). Our choices are also very influenced by larger social determinants of health such as education and literacy, childhood experiences, and income.

Note: For Indigenous Peoples, there are additional determinants beyond those specified by Western scholars and practitioners, which include: language, culture, and place, geography and location, strong self-identity, racism free environments, colonization and systemic racism, intergenerational trauma and legacy effects, and access to health services (Indigenous Primary Care Council, 2022, p. 19).

Health inequities are a result of factors that are **unfair, unjust, or modifiable** (WHO, 2021). Adopting a **health equity-oriented approach** means that you strive to identify and address unfair systems and policies that create health inequalities and increase access to conditions conducive to health for all (Government of Canada, 2024; WHO, 2021).

Watch the video of Dr. Smith speaking briefly to the concept of health equity.

Start of the video transcript:

What is health equity?

[Text on video reads] What is health equity? Do you think we should talk about health equity or social justice?

[Spoken] So, public health has two primary aims: one is to simply improve the health of the population and the other is to do that in an equitable fashion. So, in essence really, public health is trying to improve health and then, at the same time, think about how health, and the burdens that affect us, are distributed across the population.

So, health equity is the ethical idea that is guiding that second aim, to think about how do we do this in an equitable fashion. So, health equity is defined as the absence of differences in health in the population that we consider to be unjust. So health inequities, then, are differences in health between people that we think are unjust.

So, clearly, we need some idea of what would constitute an unjust difference in health. And to do that, we look to accounts of justice. So, the whole idea of health equity, right in its definition, is this idea of justice, so we need some better accounting of what that actually requires or looks like.

So, when it comes to trying to identify health inequities and unjust differences in health, we need to ask what makes a difference in health between people actually unjust. Is every difference in health between people unjust, or is it only a subset of those differences that we are morally concerned about as a matter of justice?

And so, most commonly, we would think that things that are socially controllable, things that have socially-controllable causes that lead to differences in health, are unjust. And so, it's only that subset, things that we can control, that come from social conditions, that we would say are unjust differences in health. And so, that's why, when we talk about health equity, we need to be talking about social justice.

Because social injustices, whether it's rooted in racism, sexism, any form of oppression, are important to us as a matter of health equity.

And so, conversely, we need to think about what our aim is when we're trying to achieve health equity. So, we need to be able to identify what differences in health are unjust, but we also want to say "What would a just state of affairs look like?" Is it equal health for everybody? Is it equal opportunities for everybody to be healthy?

Is it everybody getting an equal amount of resources to be healthy?

Or maybe we don't care about equality at all, and we might just think maybe we just need to set a threshold where we say everyone should be at least that healthy, beyond that we don't really care how healthy they get. And to do that we need an account of justice to think through what health equity actually requires from an ethical standpoint.

End of the video transcript

Power, Privilege, and Positionality

Issues of power and privilege are important aspects of enacting culturally safer, equity-oriented primary care. It is important to critically reflect on where is power located within the therapeutic relationship:

- Is it shared?
- How does it shift, if at all?
- How does privilege impact the lens in which we practice and understand the people we are there to support? What are the effects of power and privilege in this context?

We offer the "**Coin Model of Privilege and Critical Allyship**" by Dr. Stephanie Nixon as a mental map in which to start to conceptualize systems of inequality. As Dr. Nixon notes, the model focuses on privilege, and what to do with it and about it in order to accountably take up our roles in the struggle for justice for all.

The "**Coin Model of Privilege and Critical Allyship**" is a way of translating core concepts in anti-oppression.

While the coin metaphor may be new, the ideas about power and privilege are very old.

Recommended Resources

Provided are links to an open-access, peer-reviewed article designed to build capacity about privilege and anti-oppression using this coin metaphor. While it is published in a scholarly journal, it was written to use plain language and be as accessible as possible to a wide range of audiences. The article focuses on implications for health, but the ideas are transferable to other topics.

Continue to learn more about the Coin model.

The coin model of privilege and critical allyship: Implications for health

English Version

Le Modèle de la médaille, de privilège et de l'alliance critique: Implications pour la santé

French Version

Understanding the role of privilege in relation to public health ethics and practice

English with English captions

Understanding the role of privilege in relation to public health ethics and practice

English with French captions

11 Questions about Privilege and Critical Allyship

English Version

11 Questions et réponses sur le Modèle de la médaille

French Version

"I first noticed how power shifts in my relationship with patients when I saw them in the clinic then at their home. When they came to clinic, I acknowledged that I had more power. I could decide, time, physical location of our meeting, typically I also led the conversation. When I visited them at their home, power shifted, I was entering their space. They led where we moved, in many cases how the conversation unfolded as well. This sharing of power and space and being able to work in both spaces – clinic and home – was one of the aspects of working in team-based primary care that I loved the most as a result."

- Occupational Therapist

We also offer Sylvia Duckworth's model of Power and Privilege adapted for the Canadian context in which to understand privilege (Government of Canada, 2022).

When looking at the wheel from an intersectionality perspective, consider people who might have one or more of the outer layers of the circle. For example, a homeless Indigenous woman who is neurodivergent. What are the ways in which we can promote culturally safer, equity-oriented healthcare for her within a primary care setting?

Pulling it all together: Highlighting Ontario's Indigenous Primary Health Care Council

Important initiatives are underway related to advancing cultural safety and health equity, specifically for Indigenous Peoples. The mission of the Indigenous Primary Health Care Council (IPHCC) is to use Indigenous solutions to transform Indigenous health outcomes and decolonize health systems (IPHCC, n.d.). This is achieved by:

- Empowering the voices of Indigenous Peoples and communities to effect change.
- Partnering with Indigenous communities, mainstream health organizations, and government agencies.
- Gathering and sharing data about the health status of Indigenous Peoples in Kanadario (Ontario) and inequitable service gaps.
- Equipping Council members with the tools, training, and networks to provide quality health care.

Recommended Resource

Continue to learn more about the Indigenous Primary Health Care Council.

Practice Scenarios

To conclude this section, two practice scenarios have been provided to help you practice identifying strategies to promote accessibility and equity in your primary care practice.

Scenario 1

Clara

Clara is a 33-year-old single mother with two young children. She lives in an apartment across town from her family doctor's office. Clara has struggled with anxiety and depression for most of her adult life. She is motivated to attend her regular appointments but finds herself having to cancel (often last

minute) or misses her appointments because she is unable to find childcare or because of her commute on public transit with small children, especially in the winter months.

What can the primary care team do to help Clara attend her appointments?

Reflect on what the primary care team can do to help Clara attend her appointments. Then continue for some examples.

The primary care team can:

- Advocate for the clinic to provide bus tokens, taxi chits, or other transportation like uber
- Offer a clinic that gives young children activities while parents are in their appointments
- Offer virtual appointments
- ***Scenario 2***

Mae

Mae is a 61-year-old Indigenous woman diagnosed with end stage chronic obstructive pulmonary disorder (COPD). She has a supportive family who are providing great care for her at home and can bring her to all of her appointments. Mae's first language is Ojibway but has learned to speak English fluently. Her family has noticed that with her functional decline and progression of her illness, she has resorted back to her mother tongue making communication difficult as none of her children speak the language.

Mae is palliative and her wishes are to die in her own home. Her family is worried that they aren't prepared for Mae's condition to decline and are not sure what else they need to do at home to support her.

How can the primary care team assist Mae and her family?

Reflect on what the primary care team can do to assist Mae and her family. Then continue for some examples.

The primary care team can:

- Advocate for a translator to attend appointments
- Write down key words and their translation to English
- Complete in-home safety assessment for equipment
- Provide energy conservation strategies
- Family counselling
- Advocate for education for family (e.g., medication management, advanced directives)
- Inquire about spiritual care/traditional healing for Mae and family

In this section, you learned about cultural safety, cultural humility, power, privilege, and positionality. You were introduced to models, strategies, and practice scenarios for identifying strategies to advance culturally safer, equity-oriented primary care.

Continue to Section 1.4

Page links:

https://www.projectimplicit.net/

https://www.healthcareexcellence.ca/en/what-we-do/all-programs/cultural-safety-design-collaborative/

https://www.nccih.ca/495/A_conceptual_framework_for_Indigenous_cultural_safety_measurement.ncch?id=10375

https://doi.org/10.1177/1043659615592677

https://www.youtube.com/watch?v=39cIpZWzrpU

https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-7884-9

https://rehab.queensu.ca/source/Research/SN/Accessible-French-Coin-Model-Article-PDF-Taggings.pdf

https://www.youtube.com/watch?v=a30a_NiT5zc&list=PLNWUsONW1NHKByYnDkqHAFpoCXcGuIGa4&index=5

https://www.youtube.com/watch?v=4qUc5rS0dq8&list=PLNWUsONW1NHJrtPFHS3Kje_gwg3bWysmX&index=5

https://rehab.queensu.ca/source/Research/SN/11-Questions-about-Privilege-and-Critical-Allyship-ENG.pdf

https://rehab.queensu.ca/source/Research/SN/Questions-et-reponses-sur-le-Modele-de-la-medaille-FR.pdf

https://iphcc.ca/

1.4 ROLES AND SCOPES OF PRACTICE

Through this section you will learn about six professions: audiology, dietetics, occupational therapy, physiotherapy, social work, and speech-language pathology. You will be introduced to three different case studies and reflect on how the different professions might approach each case.

Learning Objectives

By the end of this section, you will be able to identify the breadth of roles and scopes of practice in interprofessional primary care. More specifically, you will be able to:

1. Use case-based learning to identify the different roles and scope of practice of interprofessional providers.
2. Explain the foundational knowledge/lens that each profession brings to primary care.
3. Be able to define shared domains, identify area of intersection, and articulate the fluidity of roles within interprofessional, collaborative primary care practice.

Professional Roles

Audiology

An audiologist specializes in diagnosing and treating hearing and balance disorders. They conduct hearing evaluations, diagnose disorders like hearing loss and tinnitus, and develop personalized treatment plans. This may include fitting hearing aids, providing counselling, and offering rehabilitation for balance disorders. Audiologists also educate patients and conduct research to advance understanding and treatment in the field.

Video Spotlight

Watch the video of Bonnie, an audiologist in Ontario, speak about the importance of her role and primary care.

Start of the video transcript:

I am an audiologist. I have worked in private practice, in a hospital setting, with a hearing aid manufacturer, as an educator, and currently as the director of audiology with a professional association.

Although I do not currently work in primary care, when I consider my potential role in primary care, I get most excited about being able to provide my patients with more holistic and integrated hearing health care.

One example of how I could envision my role within a primary care team would be that I could ensure that the overall patient experience is positive and informative, by ensuring communication access for my patients, and by educating my team members about what communication access means.

In addition to this, I could ensure that my patient has a more positive experience interacting within our community, by providing educational sessions for my patients, their caregivers and families, my teammates, and other professionals within my community on different topics, areas, surrounding hearing health care.

End of the video transcript

Continue to learn more about Audiologists as part of team-based primary care.

Dietitian

Dietitians are Regulated Health Professionals with a university-level education in food and nutrition sciences enabling them to use the nutrition care process to perform nutritional assessments, diagnose nutrition problems, plan and implement nutrition interventions to manage nutritional problems, as well as monitor and evaluate nutrition status.

Dietitians base their practice on evidence and can translate scientific evidence in practical everyday solutions to promote health and help manage nutrition-related conditions like diabetes, obesity, cardiovascular disease, allergies, cancer, etc.

Video Spotlight

Watch the video of Marg, a dietitian from Ontario, speak about her work in primary care.

Start of the video transcript:

Hi, my name is Marg Alfieri. I am very happy and proud to be a primary health care dietitian for the last 20 years. I work in a family health team at Kitchener-Waterloo in Ontario.

Primarily, we practise the science of medical nutrition therapy, and I call it the science because it is based on proven outcomes, use of randomized controlled trials.

We do use a Mediterranean diet extensively, because there are a plethora of randomized control studies that actually prove that it is a treatment [for] depression. You know, there's a SMILE study, to prevention of diabetes, the treatment of diabetes, hypertension, hyperlipidaemia. Pretty well, just about anything, the Mediterranean diet can improve outcomes from, of course, haemoglobin A1C, to all the liver profile, to blood pressure, and depression.

We have developed toolkits across Canada that support the delivery of medical nutrition therapy.

The Hamilton Super Fit has been remarkably generous in not only creating numerous toolkits from their mental health, to the bariatric, to the mindful eating, Healthy You, but they have generously given them to the primary health care dietitians across Canada, not only in the first iteration, but also in subsequent as they keep updating it. All of the updates are provided free as well.

We have other Fits, for instance, the Barrie Fit, in Barrie, Ontario, that are currently working on a great ozempic dietician pharmacy-led seminar, which is sort of a gateway to more health promotion and health intervention group seminars.

In Ontario at least, the vast majority of our time is seeing patients individually, whether it be in-person, or through virtual Zoom, Teams, and many of us do a hybrid model seeing people in-person or virtually. I'm 100% virtual at the moment, and I find that its - patients still, even, sort of, post-pandemic are very grateful for that as well.

One of the best parts, I think, two things about the primary health care dietitians, in Ontario specifically, because of horrible recruitment, and retention, and lack of a liveable wage, we actually banded together and

helped not only dietitians, but all health care professionals, from receptionist to executive directors get a pay increase, which was 325 million dollars delivered over four years.

That was - it sounds easy. It was an incredible amount of work by hundreds of dietitians. We had about 130 dietitians that we marched on Queen's Park. Very effective. The funding flowed very quickly.

The other great part about it is collegiality. We created a community of practice that was, continues to be supported by Listserv. Phenomenal friendships have been created, and questions being answered on the Listserv.

So that's a few, just a few of the reasons why I love being in primary health care.

Thank you.

End of the video transcript

Continue to learn more about dietitians in primary care through three simulations.

Vegetarian Woman with Prediabetes

Adolescent with Eating Disorder

Diabetes and Renal Insufficiency

Occupational Therapy

Occupational therapists help individuals across all age groups and health conditions to participate in everyday activities (occupations). Occupational therapists assess individual and environmental factors that impact participation and overall function; considering the physical, mental, and spiritual aspects of the person along with the physical, social, cultural, and institutional aspects of the environment.

Video Spotlight

Watch the video of Todd, an occupational therapist from Ontario, speak about his work in primary care.

Start of the video transcript:

Hi, my name is Todd Tran. I'm an occupational therapist working in primary care, and I work at Women's College Hospital in Toronto, and I've been working as an occupational therapist for over 20 years, and working in primary care of that probably 15 years now.

And one of the reasons why I love working in primary care is that, as an occupational therapist, I'm able to practise at full scope, which means I can work in physical rehab, such as providing splinting interventions for an individual that may need it, or also, providing supportive counselling for individuals that would like help with their emotional needs.

One of which, my love working in primary care, is running groups.

And one of the groups that I run is a mindfulness-based intervention group that supports people with emotional distress, anxiety, to help with mood, sense of well-being, and improved quality of life.

One of which is, my interest is mindfulness. And, as such, I went back to do my PhD, and now I am a clinical/ researcher in primary care and loving it. So. Yeah.

End of the video transcript

Continue to learn more about occupational therapy in primary care.

Physiotherapy

Physiotherapists are function and mobility experts who can support individuals to reduce the risk of functional decline, improve functional abilities, and restore function and mobility for people who are experiencing functional limitations. Physiotherapists provide person-centred care that can help enhance an individual's ability to work; participate in recreational activities; and care for themselves, their home, and their family. Physiotherapists add particular value to team-based primary care for persons or groups experiencing functional limitations when recovering from injury, recovering from an acute health condition, or managing a chronic condition.

Video Spotlight

Watch the video of Ontario physiotherapist, Brian, speak to the benefit of an ongoing relationship with clients in primary care.

Start of the video transcript:

Hi, my name is Brian Pearce and I'm a physiotherapist working in primary care in downtown Toronto at Parkdale Queen West Community Health Centre.

What I love most about working in primary care is being part of a diverse interprofessional health care team, including physicians, nurse practitioners, registered nurses, a diabetes team, chiropody, case management, and a counselling team.

I really feel that this innovative model of care really helps to address these social determinants of health and recognises that physical health, mental health, and social well-being are all interrelated.

I also appreciate that when you work in primary care, we're not looking at things from an episode of care perspective, but rather we're looking at the longitudinal health care outcomes of our clients.

This is important in understanding that true health behaviour change, and true physical change takes lots of effort and takes a long time.

As a physiotherapist in primary care, we have the luxury of being able to see that change over time.

End of the video transcript

Continue to learn more about physiotherapy in primary care.

Social Work

Social workers are vital members in the delivery of primary care services. As experts in providing biopsychosocial and mental health services, social workers offer clinical care and psychotherapy within the context of the social determinants of health. Social workers also offer a range of other types of care

including health promotion, patient education, palliative care, lifestyle counselling, and chronic disease management, as well as a variety of services including case management, resource navigation, and collaboration with internal and external stakeholders.

Speech-Language Pathology

A speech-language pathologist specializes in assessing, diagnosing, and treating communication disorders (such as speech, language, fluency, and cognitive-communication disorders, among others) and feeding and swallowing disorders.

They conduct screenings, evaluations, develop individualized treatment and rehabilitation plans, provide therapy, offer counselling and education, collaborate with other healthcare professionals, advocate for patients, and contribute to research and education in the field.

Video Spotlight

Watch the video of Miranda, a speech-language pathologist, speaking to what she enjoys about working as a member of a primary care team.

Start of the video transcript:

My name is Miranda, and I'm a speech-language pathologist at a family health team working in primary care.

My favourite thing about working in primary care is my varied caseload.

I have clients who are toddlers with developmental language concerns, kids with articulation concerns, and adults with dysphagia, and everything in between.

I like that this is a challenging role that constantly challenges me to keep my clinical skills up-to-date in all areas.

End of the video transcript

Continue to learn more about speech-language pathologists as part of team-based primary care.

Note: Foundational to all professional roles is effective and accessible communication.

Continue to learn about fostering accessible communication in team-based primary care.

Interprofessional Areas of Practice

Consider the selection of professional roles just described to you (audiology, dietitian, occupational therapy, physiotherapy, social work, and speech-language pathology). Challenge yourself with what you think you know about each of these roles compared to the breadth of knowledge and skills that these professionals can bring to a primary care team.

Continue for general scopes of practice for the different professional roles.

Audiology

- Hearing loss.
- Vestibular function and balance.
- Tinnitus, hyperacusis, and misophonia.
- Aural (re)habilitation (hearing aids, cochlear implants, speech-reading classes).
- Cerumen management.
- Ototoxic monitoring.
- Hearing conservation program.
- Educational services (room acoustics/signal-to-noise ratio, parent teacher education).

Dietitian

Management of nutrition-related questions and challenges across the life cycle (e.g., pregnancy and lactation, introduction of foods, picky eating, optimal growth and development, older adults)

- Chronic disease management (e.g., diabetes, cardiovascular disease, gastrointestinal disease, renal disease)
- Food intolerances and gastrointestinal upset
- Allergies
- Disordered eating and eating disorders
- Sports nutrition
- Managing dysphagia
- Food insecurity
- Screening, prevention and treatment of malnutrition

Occupational Therapy

- Supporting clients in participating in occupations that are meaningful and necessary for them by addressing physical and mental health barriers, social conditions, and environmental barriers preventing them from participating in given occupations.
- Working with clients living with chronic mental and physical health conditions – providing strategies to self-manage their condition including developing everyday habits and routines that support physical and mental well-being.
- Conducting developmental screening and assessing physical, affective, and cognitive abilities of children to support participation in play and school activities.
- Supporting working Canadians by assessing work capacity and workplace accommodations, including ergonomics and accommodations.
- Prescribing adaptive aids, assistive technology, and equipment for home, work, and the community.
- Conducting home safety assessments and providing recommendations for home adaptations to support aging in the community.
- Assessing and supporting cognition and perception.
- Assessing and supporting mobility including walking in the home and community as well as and the physical and cognitive components of driving.

Physiotherapy

- Comprehensive assessment and care planning.
- Formulate and communicate a diagnosis based on assessment findings.

- Interventions such as education, exercise, pain management, and self-management support.
- Individual and group-based care.
- In-person and virtual services.
- Collaboration on innovative programming and models of care to improve healthcare experiences, outcomes, and efficiencies that meet the needs of individuals and communities.
- Participation in program evaluation and quality improvement initiatives.

Social Work

- Clinical care through in-person and virtual methods with individuals, families, or groups; social workers assist with identification, assessments, treatment, counselling, follow-up, and recovery.
- Assessments range from broad biopsychosocial assessments to understand the needs of patients, to focused assessments (i.e., mental health, cognitive evaluation, disability, quality-of-life) and risk assessments (i.e., suicidality, intimate partner violence, elder abuse, child neglect and family support, social risk).
- Counselling and Psychotherapy.
- Case management to coordinate and manage various aspects of patient/client care.
- System navigation to support clients in accessing resources and services within the healthcare system and the wider community.
- Consultation within primary care teams to advise on best ways to support and manage patients'/clients' health and wellbeing considering the impact of broader holistic, systemic, and historical factors.
- Community engagement to build partnerships with organizations and agencies that can offer additional services and accept referrals for ongoing support for clients outside of primary care.
- Leadership through informal and formal roles in facilitating teamwork, collaboration, change management, and systems transformation to promote direct patient care and team functioning.

Speech-Language Pathologist

- Speech development (delays, apraxia, etc.)
- Language development (delays, autism, etc.)
- Pre-literacy and literacy skills (reading/writing, dyslexia, etc.)
- Fluency (stuttering)
- Voice and resonance (hoarse or unsustainable voice, gender-affirming, etc.)
- Swallowing and feeding
- Acquired speech and language difficulties (stroke, primary progressive aphasia, brain injury, etc.)
- Cognitive-communication (concussions, brain injury, dementia, etc.)
- Hearing-related communication

Case Studies

These case studies were designed to help you apply your knowledge of the roles and responsibilities of the health professionals described in an collaborative, interprofessional approach to practice.

Case Study 1 - Xu

Xu is a 54-year-old Winnipeg man with long standing history of neck and low back pain. His neck and back pain have been present for about 10 years, and his low back pain worsened about 3 months ago after a fall down his front steps.

Xu works as a software engineer but has been off work for the past 9 months as a result of his ongoing pain. Pain in his low back is 7/10 at rest. The pain increases to 10/10 with lifting, standing for > 30 minutes, or sitting for > 45 minutes. Pain in his neck is 6/10 at rest, and 8/10 when sitting at the computer for more than 30 minutes. Xu is also an artist and enjoys both painting and pottery, but has been unable to do either for a significant amount of time.

Xu is unsure what he should do. He is worried about the thought of returning to work and is finding himself becoming less and less motivated.

His daily routine has changed significantly, which has impacted his sleeping and eating schedule. Xu often sleeps late as he reports he finds it challenging to find a comfortable position to fall asleep, so he prefers sleeping on the Lazy Boy chair while watching TV. He finally heads to bed when he stirs around 4 am.

He received some updated paperwork regarding sick leave and long-term disability (LTD) and is setting up an appointment with his primary care clinic physical therapist to work on alleviating pain in his neck and back.

Continue to learn how two different professions might approach Xu's case.

Physiotherapy

A physiotherapist could help Xu by completing a comprehensive assessment to formulate a diagnosis, and collaborating with Xu to develop a management plan.

- The subjective history would include collecting additional information, including information about the patient's concerns, relevant past medical and health history (including comorbidities, medications, and other treatments), aggravating and relieving factors, paresthesia or weakness, and screening for indicators of pathology that may be contributing to the back or neck pain (i.e., "red flags")
- The subjective history would include an understanding of Xu's current functioning and goals for return to function
- Assess for any social determinants of health which may be impacting Xu's health including social connectedness, financial security, housing, and food security
- Assess for Xu's ergonomics when working at the computer
- Assess the physical requirements for Xu's job
- The objective assessment would include: postural assessment, movement patterns, functional analysis, range of motion, muscle strength and length, and mobility

From the information provided and the findings from the assessment, the following interventions could be considered:

- Education regarding Xu's diagnosis, prognosis, and treatment options

- Pain education, in particular how anxiety can affect an individual's experience of pain
- Education regarding strategies for managing pain; this could include movement and postural strategies (including positions for pain relief), therapeutic exercises, and manual therapy to improve pain and improve range of motion if indicated
- Make recommendations regarding a return to work plan
- Initiate referrals to or engage appropriate team members, including mental health therapy (to address anxiety and low motivation), and possibly to family physician if any diagnostic testing or a medication review is required

Occupational Therapy

Occupational therapy services start with an initial interview/assessment to understand his daily routine and identify the impact of his pain on everyday activities as well as his mental health.Explore his social supports at home and work.

Physical assessment within the primary care clinic to examine his postures during everyday movements including bending, sitting, standing, lifting, carrying objects.

Potentially assess his home and possibly his work setting, focusing on his desk spaces to ensure appropriate office ergonomics (chair, desk, organization of his workspace) – as well as leisure spaces at home (e.g. painting/pottery).

Conduct a detailed job analysis to determine both physical and cognitive work demands as well as understand the physical and social environment.

Occupational therapy will use a range of different approaches to support Xu in returning to work, participating in his leisure activities and establishing a routine.

1. Establish a structured program to help him slowly increase his sitting tolerance for computer use, painting and pottery (grading these activities over time).

2. Educate

- to support sleep hygiene practices
- posture and body mechanics, including sleep postures.
- about acute and chronic pain as well as pain management principles (pacing, planning, prioritizing)

3. Adapt/Compensate

- consider adaptations to painting and pottery to enable modified participation while he works to gain his capacity (e.g. stool, handbuilding vs wheel, tilted easel)

4. Consult

- depending on the requirements, collaborate with his physician/NP to support the completion of insurance forms

Case Study 2 - Finn

Finn is a 5-year-old boy who is experiencing significant speech and language development delays. He can understand spoken language but struggles with speech issues as well as reduced fluency and literary skills.

Finn often acts out at school which disrupts the entire class. He is easily frustrated, especially related to communication issues, but has experienced some academic success in other areas like math. He is often late to school and his mother often states the mornings are always "a mess." His diet, both at school and at home, is extremely limited and typically includes a combination of Cheerios, saltine crackers, white bread with butter, chicken fingers, and green grapes.

His parents Pietro and Gwen both work low wage jobs at a local butcher and grocery store, with very little ability to take time off during the workday. Neither of his parents have access to extended health benefits, both have low health literacy levels, and struggle with Finn's needs. Finn is also the oldest of three children.

Finn has very few friends at school and is not involved in any activities. His parents report that most of Finn's time is spent playing video games and that he becomes extremely agitated when asked to turn off his games, and both Pietro and Gwen have stated that they don't have the energy to deal with him, so Finn is often utilizing screens for hours every day.

Gwen and Pietro have called the clinic to set up an appointment for Finn.

Continue to learn how six different professions might approach Finn's case.

Speech-Language Pathology

Speech-language screening in the pediatric population is a pass/fail procedure to identify children who require further speech-language/communication assessment or referral to other professional and/or medical services. Given Finn's history, a comprehensive speech/language assessment is warranted. Prior to assessment, it is recommended that Finn undergo an audiological screening/assessment to ensure he does not have any hearing impairments or disorders that may interfere with normal speech and language development.

The SLP could assist Finn and his parents by:

- educating Finn's parents about typical speech and language development based on age-appropriate norms
- describing the effects of speech, language, cognitive-communication, and/or swallowing impairments on Finn's activities, participation, and performance in varied contexts
- educating Finn's parents and other team members regarding the importance of optimal speech, language, and cognitive-communication development for listening, speaking, reading, writing, and thinking skills
- providing recommendations for speech-language assessment, intervention, and support
- performing or referring to another SLP who could perform a comprehensive speech and language assessment, which includes speech, language, literacy, fluency, cognitive-communication, and/or swallowing function

- referring Finn to professionals that specialize in pediatric dysphagia and feeding disorders and/or dietitian and/or pediatrician as needed based on his atypical feeding behaviours and risks for atypical growth and health
- assisting Finn to acquire new spoken and written language skills and communication strategies (verbal and nonverbal) to help him maximally engage in his interpersonal relationships, and give training on how to use appropriate communication accommodations and supports, analyze their effectiveness, and reduce barriers to their use
- liaising with care team members in other settings (teachers, school SLP, after-school program, etc.) to ensure appropriate follow-up

Dietitian

- Enhancing food literacy - providing basic nutrition knowledge in a way they can understand for parents and children
- Optimizing Finn's nutrition status, assessing growth pattern and trajectory, nutrition status, increasing acceptance of a variety of foods using approaches such a food chaining
- Offer ideas to expand Finn's diet, possibly using a combination of food chaining principles and Division of Responsibility principles
- Using pictorial handouts for food literacy
- In additional to routine care under the scope of dietetics, provide patient-facing resources to support the navigation of publicly-funded community support services in the local communities/sub-region to address priorities issues and patient/caregiver needs related to diet quality/food security
- Offer same-day appointment with other disciplines or group medical visits to reduce lost income/increase likelihood of seeking team-based medical care
- Address food security, accessing food banks, education on ways to save money at the grocery store, building a balanced meal on a budget, etc.

Social Work

Viewing both Finn and his family as their client, the team's social worker would conduct a strengths-based, whole-family biopsychosocial assessment, speaking to Pietro, Gwen, and Finn, as well as Finn and his parents separately, about sources of support and resources (including supportive persons, friends, and specific strengths and interests). This assessment would be supplemented by reviewing Finn's electronic health record, and consulting with Finn's physician (about health conditions, and possible specialist referral). They may arrange a meeting with Finn's teacher to provide collateral information about Finn's 'outbursts': when they happened, what they looked like, and how were they treated at school to support treatment planning. In consultation with the whole family, they would also co-construct individual and family-level goals for social work intervention with each member, and for Finn's family as a unit.

The social worker could arrange concrete support for Finn and his family, connecting them with funding supports for persons without health benefits, and low/no costs community resources and activities relevant to their interests and strengths to support the whole family unit. They could also connect Finn's family with the team's dietician to explore ways of helping Finn (and his family) explore new foods.

The social worker could provide psychoeducation to Gwen and Pietro about Finn's needs, to assist with how they related to him. They could support this with motivational interviewing and solution-focused brief therapy to explore how Gwen and Pietro could support each other, and Finn, differently. This could also be supported with cognitive-behaviour skills training that Gwen and Pietro could model for Finn, to also be offered to Finn in an adapted and age-appropriate manner. If offered, they would collaborate with the speak-language pathologist, physician, and dietician outlined above to support Finn's use of these skills.

Audiology

SLP has referred Finn to audiology. In a case like this, a hearing check (screening or full hearing test) should always be the first action item. Even though it is reported that Finn can understand spoken language, it could be that he is still experiencing a mild-moderate hearing loss that may be impacting his speech and contributing to his behavioural issues.

A hearing screening should be conducted at the beginning of Finn's visit to help inform the care pathway. If Finn in fact has a hearing loss (e.g., mild due to fluid build-up in his middle ear), that will change the trajectory of his care and his speech therapy services dramatically.

Physiotherapy

In this situation, the physiotherapist may be helpful as a consultant for other primary care team members. A physiotherapist could suggest some additional subjective assessment questions, supports to promote increased physical activity, and potential navigation to other physiotherapy services in the community.

- **Subjective assessment:** Does Finn have difficulties in gym class, using stairs, or with getting dressed independently? Do his parents ever identify Finn as 'clumsy'?
- **Physical activity:** Based on Finn's interests, and family and community resources, are there ways to encourage more physical activity through play?
- **Navigation:** Are there supports through school health or a Children's Treatment Centre for physiotherapy? If Finn does have any gross motor deficits, these programs would help get him the accommodations needed at school and potentially at home.

It is important to keep in mind the potential for a diagnosis of Developmental Coordination Disorder (DCD), characterized by difficulties with articulation, ADHD, and gross motor deficits. Many children with DCD are frustrated by the challenges of completing physical tasks and of communicating these challenges to others. DCD must be diagnosed by a physician, and the diagnosis is often needed to access supports in learning plans at school.

A physiotherapist might help team members assessing or screening for motor issues when working with children, such as throwing and catching a tennis ball in the office.

Occupational Therapy

To gain a better understanding of Finn and his needs it is important to understand his daily activities and routines, and the environments that he lives and plays in.

Assessment: As Finn's communication is limited it is important to gain as much information as possible in the first appointment from Finn's parents like understanding Finn's early feeding, connection/soothing, developmental goals, and social experiences. Some of this may be identified in the EMR.

1. **Sensory:** Meeting Finn first in the clinic and then in his home environment to understand what activities Finn likes or doesn't like (Sensory Questionnaire)
2. **Social Connections:** Discuss his connection needs
3. **Communication and Learning:** Reaching out to his school and teacher
4. **Environment:** Potential opportunity to work with the school-based OT or support referral. If school-based OT is not available, go to the classroom to determine what may be impacting his ability to regulate. What can be modified? Understand how Finn interacts with his peers and the activities he enjoys and his daily school routines.

Intervention in Primary Care:

Discuss communication/learning needs. Talk about the different ways we can communicate. Use examples that are common at home.

1. Abstract/concrete information
2. How many instructions can he do at one time?
3. Does he like routine or does he not like routine?

Then discuss behaviours and when they start to see behaviours as it relates to the points above. Then talk about how what they now know about Finn can impact school and that environment. Create some strategies based on activities that he enjoys and how to integrate them into his activity in a way that supports the tasks he is trying to do.

- Are there things that work at home that could work at school? If there is decreased capacity to trial these things at home, try to integrate some suggestions at school.

From the knowledge above, use the information to meet with teacher and see the school environment:

- Discuss the above findings. What can be added to give him more opportunities to meet those needs? What type of instruction does he need? What does he need to feel safe and secure in the classroom?
- Develop some coregulation strategies based on Finn's needs that will help him when he is starting to get overwhelmed and discuss how to work through those feelings. Often this is impacted by removing any unwanted stimuli and adding in sensory opportunities that he enjoys. This could also be important for learning how to socialize.
- May have difficulty with free play and may need more guidance. May need to understand rules. Etc.

Recognizing Finn's triggers and his physical changes will help him to be able to integrate the suggestions in a timely manner and it will help to teach Finn how to recognize his body's changes and what he can do to calm himself as he gets older.

Case Study 3 - Harriet

Harriet is an 82-year-old woman living with her husband Luis in a two-story century home in downtown Kingston, ON.

Harriet was diagnosed with osteoporosis 10 years ago when she was bending down to tie her shoe and experienced excruciating back pain. At that time, she was taken to emergency and discovered she had fractured her lumbar vertebrae (L2). Bone density testing revealed a T score of -2.6. A decade later, Harriet's back pain has continued, and in addition, she has a kyphotic posture and has lost significant weight in the past year and is currently 95 pounds (BMI 19).

Harriet had a fall 2 years ago and landed on her right wrist. The fracture improperly healed, and she has lost significant mobility in her wrist – primarily extension and ulnar deviation. Harriet has glaucoma, which she manages with eye drops. She finds it difficult to use the drops due to her limited wrist ROM. Harriet was also fitted for hearing aids about 5 years ago, however, she often struggles with them and feels they aren't doing what "they are supposed to do."

Both Harriet and Luis have always been active, enjoying hiking, biking, and walking. Harriet currently walks to the synagogue each day (1 km), however this has become increasingly difficult. She has begun to take a cab home, as Harriet no longer drives, and Luis lost his license 3 years ago following a diagnosis of mild cognitive impairment (MCI). Harriet's daughter purchased her mother a cane for her walks, but Harriet seldom utilizes it as she feels that any ambulation aids are for little old ladies. Harriet thinks the bus might be a more affordable transportation option but doesn't know how and is nervous about falling on the bus.

She has always been responsible for maintaining the day-to-day home activities including cooking, cleaning, and laundry, and continues to do so, however she is finding herself exhausted at the end of each day. Harriet has also noticed that she needs to make softer foods more often as she has had a few choking episodes which have really frightened her. She also finds that her voice can sound "strained" or "hoarse" off and on and wonders if it is related to her choking episodes or if it might be something else.

Harriet has experienced an increasing number of falls over the past year, with her most recent fall 2 weeks ago. She fell in the bathroom getting up from the toilet as she reached for the towel rack for support, and it gave way. She hit her head, right shoulder, and hip, and sustained significant bruising, but no fractures. Harriet underwent a series of x-rays and was sent home.

Harriet is feeling overwhelmed and is becoming fearful of having another fall that might jeopardize her ability to remain in her home. Harriet and Luis' neighborhood has changed significantly over the years and very few of their friends remain, which has impacted their social life.

The primary care occupational therapist has been supporting Harriet and is looking to further collaborate with her primary care team members.

Continue to learn how six different professions might approach Harriet's case.

Occupational Therapy

An occupational therapist (OT) has already been seeing Harriet. There are issues related to Harriet's daily activities (occupations), her physical capacities, and her environment – all of which might be a focus of assessment and intervention.

Assessments: If they haven't already been done, the OT in primary care might consider the following assessments with Harriet:

- Identification of occupational priorities: the OT might interview Harriet to understand which activities are important to them both for Harriet to be able to continue doing. This will give the OT direction for future assessments.
- Home assessment: to get a sense of how Harriet (and Luis) is currently managing, the OT would likely visit them at home and conduct a home safety assessment. A standardized form like the HOME FAST might be used to help the OT identify key home safety risks.
- Activities of daily living/self care: the OT may observe how Harriet manages tasks like dressing, toiletting, and bathing/showering.
- Instrumental activities of daily living: the OT may observe Harriet in her kitchen and doing laundry to assess strengths and challenges for Harriet in this area.
- Community mobility: in collaboration with the physiotherapist, the OT may want to explore with Harriet her ability to manage mobility outside of her home (e.g., to walk to synagogue, manage groceries, banking etc.).
- Physical function: in collaboration with the physiotherapist, the OT can explore Harriet's fall risk (balance, proprioception, strength, range of motion, physical endurance, pain).

Interventions:

- Home modification recommendations: the OT is likely to make recommendations for minor home modifications to improve home safety (handrails on stairs, grab bars in the bathroom, bath seat, kitchen devices). The OT may collaborate with the social worker to support Harriet and Luis to manage financial issues associated with these modifications.
- Assistive device recommendations: the OT may make recommendations for simple assistive devices to support Harriet's continued function (e.g., dressing aids, kitchen devices). A mobility device may be recommended in collaboration with the physiotherapist.
- Chronic disease/pain/fatigue self-management: the OT may recommend that Harriet participate in group or individual self-management education so she learns new strategies to manage her pain, fatigue, and continues to be as active as possible.
- Community mobility planning: the OT may work with Harriet to formulate a plan for community mobility that includes public transportation.
- Falls prevention: the OT may refer Harriet to a falls program that might help her focus on increasing her strength and balance to decrease her risk of future falls. The OT might also focus on falls education in collaboration with the physiotherapist.

Physiotherapy

Initial considerations:

- As Harriet has identified the fear of falling as a big concern, a physiotherapist could assess her balance, strength, and functional abilities, and develop a plan with her to address any findings.
- One important element will be to find ways for Harriet to safely participate in meaningful activities, especially active ones, such as walking and hiking.

- Coordinate with the OT to support assessment and ongoing treatment as needed (e.g., physiotherapists could help the OT by completing standardized fracture risk assessments or mobility assessments that can help screen for future falls risk).
- Navigation: community services for Harriet may include fall prevention programs, respite care, and social and physical activity in a group setting.

Additional considerations:

- A physiotherapist would also assess Harriet for potential frailty, and discuss ways to prevent its progression or prevent functional decline.
- Chronic disease management: Harriet has persistent pain, as her back pain has been ongoing for 2 years, as well as osteoporosis. A physiotherapist can assess factors contributing to her experience of pain, and treatment may include education on the neurophysiology of pain, self-management supports, support for physical activity and exercise, and other interventions. The physiotherapist may also help identify ways to manage osteoporosis, including exercise and education.

Audiology

- An audiologist can help Harriet understand her hearing loss and can help mitigate any challenges that may arise due to her hearing loss.
- An audiologist can address Harriet's unmet hearing aid expectations and help the patient understand the capabilities/limitations of her hearing devices.
- An audiologist can counsel and potentially modify Harriet's hearing devices physically for easier insertion/battery changes, etc.. For example, is her struggle with her hearing aids due to her limited wrist ROM resulting in difficulty manipulating and inserting her hearing aids/hearing aid batteries/using the "push button" on her hearing aids or the remote control?
- An audiologist can provide training on proper use of the hearing aid (including proper insertion/cleaning); can provide counselling to Harriet on useful communication strategies; and can verify and reprogram her hearing devices to better suit her needs.
- An audiologist could perform a pre-appointment hearing screen and recommend the use of a pocket talker for every appointment that Harriet attends to each of the professionals involved in Harriet's upcoming care

Speech-Language Pathology

There are several red flags regarding dysphagia in Harriet's history, such as the presence of a cervical spine abnormality, a history of dysphagia, a demonstrated need to alter diet consistency, a history of weight loss, vocal changes, and frailty. A recent loss of mobility may increase Harriet's risk of developing a pulmonary infection if aspiration was a concern.

A speech-language pathologist can:

- Perform a clinical swallow evaluation, which may include an instrumental evaluation of swallowing, such as a VFSS/MBSS or FEES, to guide assessment and treatment
- Recommend and explain physiologically appropriate compensatory maneuvers or treatment exercises to ameliorate Harriet's dysphagia based on assessment results

- Counsel Harriet and her family on the assessment results to address the nature and impact of the dysphagia and make appropriate diet consistency recommendations, keeping in mind Harriet's values and goals
- Make appropriate referrals to other team members as needed (e.g., dietitian) if diet consistency changes are indicated and agreed upon, and perform appropriate follow-up and support

Given that Harriet also is experiencing vocal changes, a speech-language pathologist could administer a voice assessment, which may include formal or informal measures of evaluation of vocal characteristics related to respiration, phonation, resonance, pitch, loudness, pitch range, and endurance. Given that these vocal changes co-occur with dysphagia, a FEES/FEEV examination or referral to ENT may be indicated.

Dietitian

- Bone health: optimizing calcium and vitamin D intake through diet and supplemental sources
- Swallowing assessment and encourage referral to videofluoroscopy/SLP swallowing assessment
- Based on videoflouroscopy results, provide education on texture modification and look into meal delivery services
- Malnutrition assessment: optimizing nutrient intake and meal balancing
- Review vitamin and mineral deficiencies: vitamin B12 may be contributing to cognitive impairment and risk of falls
- Asking family members to help with grocery shopping/cooking
- Assess calorie and protein requirement to support weight restoration

Social Work

The team's social worker would begin by conducting a full biopsychosocial assessment, including collateral information from Harriet's husband, Luis, and possibly from Harriet's daughter. This assessment would co-occur with co-construction of individual goals for Harriet, possibly connected to being able to enjoy her home, being active, faith, and socializing based on information provided.

Counselling with motivational interviewing is likely to be an important intervention for the team's social worker. This could be offered to explore how assistive devices Harriet presently has access to, but may be hesitant to use like hearing and mobility aids, could contribute to a richer life. The social worker could consult with the primary care team, particularly the primary care physician, audiologist, dietician, occupational therapist, and speech-language pathologist, to further support motivational interviewing connected to interventions for fall prevention and choking episodes.

The social worker may facilitate access to community resources for activities consistent with Harriet's values and interests (e.g., social groups and/or mobility-appropriate hiking groups for seniors) concurrent with motivational interviewing and client-directed goal setting.

Counselling with a problem-solving orientation could be offered to Harriet to explore how she could take steps towards addressing her individualized goals. A solution-focused approach may be offered to further emphasize actions Harriett is already taking that contribute to the valued areas above. This

could be supported by cognitive-behavioural therapy if Harriet's anxiety about falls remains after interventions - from OT, for example - occur that would realistically decrease her risk.

The social worker would also take steps to directly connect with the team's audiologist regarding Harriet's reported challenges with using her hearing aids to determine possible causes (mechanical, usage, etc.).

In this section, you learned about the six professions and their roles in team-base primary care (audiology, dietetics, occupational therapy, physiotherapy, social work, and speech-language pathology). You reflected on how these professionals could collaborate as primary care team members to provide more comprehensive care using three cases. In the next section, you will learn about strategies to promote interprofessional collaboration.

Continue to Section 1.5

Page links:

https://www.uwo.ca/nca/education/team-based-primary-care/module-1-audiology/

https://queensu.ca.panopto.com/Panopto/Pages/Viewer.aspx?id=b178566c-46d4-4f98-ad39-b10900f34826&start=2.706501

https://www.can-sim.ca/accessjama/cfam-vietnamese-vegetarian-eng/#/

https://www.can-sim.ca/accessjama/cfam-eating-disorder-eng/#/

https://www.can-sim.ca/accessjama/cfam-diabetic-renal-eng/#/

https://queensu.ca.panopto.com/Panopto/Pages/Viewer.aspx?id=4ddb367e-79fe-4790-8ec8-b1480146fe25&start=0

https://healthsci.queensu.ca/sites/opdes/files/modules/ot-in-primary-care

https://queensu.ca.panopto.com/Panopto/Pages/Viewer.aspx?id=4afc0111-c07a-4a7c-b582-b14c012a054d&start=0

https://physiotherapy.ca/event/preparing-physiotherapists-for-team-based-primary-care/

https://queensu.ca.panopto.com/Panopto/Pages/Viewer.aspx?id=8caadc38-9a58-42db-9556-b10900f2d866&start=0

https://www.uwo.ca/nca/education/team-based-primary-care/module-2-slp/

https://www.uwo.ca/nca/education/team-based-primary-care/module-3-communication/

1.5 STRATEGIES TO PROMOTE INTERPROFESSIONAL COLLABORATION

This section will provide strategies for supporting collaborative interprofessional primary care. This section will also apply a model for interprofessional collaboration to Harriet's case from the previous section.

Learning Objectives

By the end of this section, you will be able to describe strategies to promote interprofessional collaboration within a primary care setting. More specifically, you will to be able to:

1. Describe examples of how primary care providers collaborate with one another and illustrate the different ways of interprofessional collaboration
2. Identify strategies to support team functioning and promote interprofessional teamwork
3. Discuss the role of the patient-person receiving care in interprofessional patient-centered primary care.

Team-Based Care Approach

Team-based care has been integrated into primary care across Canada because it improves patient safety, effectiveness, efficiency, person-centredness, and equity (Government of Canada, 2015). Effective interprofessional care requires strong, collaborative relationships between team members. This section will provide strategies for building collaborative relationships for primary care teams by describing the application of the **Interprofessional Collaborative Relationship-building Model** (ICRB) (Wener & Woodgate, 2016).

The ICRB model describes the process used by primary care providers to develop their interprofessional relationships. This model emphasizes the relationship and interactions developed among the health care providers from a variety of professional backgrounds who work together to provide high quality patient care.

Watch the short animation of the ICRB process (note the animation has no sound).

The Interprofessional Collaborative Relationship-building Model (ICRB) includes four stages:

1. Looking for help
2. Initiating Co-Location
3. Fitting-in
4. Growth Reciprocity

It is also important to note that the ICRB includes two central processes: **Collaborative Relationship Focused** and **Team Communication Strategies**.

The collaborative relationship processes focuses on the patient and requires collaboration in order to provide better care for that patient. Regardless of the different professions or different approaches, professionals understand and we trust that we are each and all working to help the patient.

Communication strategies are about developing (over time) the communication strategies that help the team and the client. For example, initially this might involve using those communication strategies

that are offered already such as team meetings, patient conferences, referrals, and the electronic medical record (EMR). Over time, communication may evolve to using more face-to-face and specific functions on the EMR, such as emailing directly instead of sending a task. Communication strategies might also include short hallway conversations in addition to the patient referral forms as providers become more familiar with one another and their interprofessional relationships continue to develop with a goal of figuring out the best way to communicate.

The Four Stages of the ICRB Model

- ***Looking For Help***

Team members recognize a need for collaboration and the primary care providers recognize that another can fulfill the identified need.

Looking for help is when the primary care providers identify ways that other health professionals could better address some of the needs of their patients. For example, a family physician or nurse practitioner may identify that the mental health needs of their patient could be better met by the mental health therapist on the team, thereby relieving some of the demand on the family physician or nurse practitioner. This stage is really important because it's about the existing team recognizing that they need help and deciding to seek help from the professional(s) who can fulfill the need be it an audiologist, occupational therapist, physical therapist, social worker, speech-language pathologist, or dietitian. Typically, only those professionals who can meet the patient's needs will be involved in any given collaboration.

- ***Co-Location***

Primary care providers are in one physical location, increasing opportunities for face-to-face communication.

Initiating co-location is geographically bringing providers together into teams. When interprofessional providers are co-located, team members often find it easier to ask another team member a quick question rather than trying to research the information or ask questions via the EMR. Providers appreciate being able to quickly connect with another provider to ensure a referral is appropriate thereby ensuring service delivery is efficient with as few waiting times as possible. When teams aren't co-located, it can take a long time to send an email, write a referral, or send an EMR message and wait for a response. Within some teams, co-location with all clinics or providers isn't possible, however, planning team check-ins with all team members (which could include off-site team members attending virtually) allows the teams as close to face-to-face communication as possible.

- ***Fitting-In***

The collaborator shares skills and knowledge that fulfill the need identified in stage 1 (looking for help) thereby meeting the patient and team's needs.

Fitting in is where interprofessionals work to meet the needs that have been identified by the primary care team, the person receiving care, and their families. Fitting in is when co-located team members start to become familiar and comfortable with each other. It's not about getting to know each other as people but it's about getting to know each other as professionals. It's where teams start to understand what each other brings to the table including the unique roles and the areas of role overlap. It's

important to understand that this stage is about discovering what other team members identify as their needs and not what we think we can do for them.

Later, once the team understands, trusts, and respects one another (because a need has been met), professionals can start teaching other team members and patients about additional skills. Interprofessional team members can only offer the things that have been identified by the team. Interprofessional education (IPE) is a tool that can be used to help with the fitting in process. This includes informal IPE, like when team members are informally chatting about issues in the office. The conversations may or may not be about a specific patient, but through these chats team members learn more about each other and know connect next time a need arises.

Team members are learning from, with, and about each other as they work on helping their patients. This is the stage in which teammates work together to meet the needs and through that process identify further needs. The model cyclical - as the team gets to know each other the needs identified will likely expand and develop and each cycle brings the team closer to the next stage, growing reciprocity.

- ***Growing Reciprocity***

Team members seek each other's perspectives, appreciating their similarities and differences from what they contribute to quality patient care.

Growing reciprocity amongst providers or between providers and a patient/family come to know and care about one another, their relationship is based on trust and respect. At this stage providers and patients value each other's personal and professional expertise, and discover shared patient care values and share the focus on collaborative relationship-focused services. During the fitting-in stage when team members share their knowledge and suggest assessment and treatment approaches, this facilitates the patient, primary care providers, and other team members to respond to the patient needs confidently. This process of knowledge-sharing, suggesting of assessment, and treatment leads to increased respect and trust amongst providers, patients, and their families facilitating growing reciprocity. There was a need, the need was fulfilled, trust and respect are built solidifying a solid collaborative relationship that leads to growing reciprocity.

Growing reciprocity opens the door to allow professionals to use their skills to full scope and negotiate role overlap thereby ensuring the patient receives high quality care.

Revisiting Harriet's Case

Think back to Harriet, who was introduced in the previous section, and the extensive list of professional skills that could be utilized to address their needs. These skills and knowledge, while important, are best provided by a group of professionals who have come together as a team.

"Interprofessional collaboration is the process of developing and maintaining effective interprofessional working relationships with learners, practitioners, patients/clients/families, and committed to enable optimal health outcomes. Elements of collaboration include respect, trust, shared decision making and partnerships."

- Canadian Interprofessional Health Collaborative, 2010

When patient needs are complex, a team ensures the right service by the right professionals is provided in a timely fashion. In Harriet's team, the members include Harriet (patient), the audiologist, dietitian, occupational therapist, physiotherapist, speech-language pathologist, and social worker. These professionals and the patient (and family) form a team where members work collaboratively. Developing a team is critical to best meet Harriet's and the family's needs.

As you have learned, the **Interprofessional Collaborative Relationship-building (ICRB) Model** is a guide for teams to use to facilitate their team growth. In Harriet's case, this is how the team may develop. It is critical to understand that teams develop over time and that wherever the team is at, they can work individually and collectively toward the next stage.

You will now apply the four stages of the ICRB model to Harriet's case.

1. Looking For Help

Team members recognize a need for collaboration and the primary care providers recognize that another individual/professional can fulfill the identified need.

Identifying the **need** for collaboration is the key to this stage. About two years ago Harriet's family physician identified that an occupational therapist was needed to support Harriet to continue her home activities. More recently, the family physician and occupational therapist agreed that Harriet's issues have become more complex, requiring a further need to collaborate with other team members to deliver the best care possible for Harriet.

2. Co-Location

Primary care providers are in one physical location, increasing opportunities for face-to-face communication. Where physical co-location is not possible, providers come together using technology (e.g., conference telephone call, via video conferencing such as Zoom, Microsoft Teams, etc.). The idea being that providers come together around a particular patient to identify the initial or emergent needs.

Harriet's primary care team happens to be mostly co-located, although the audiologist is not on site. Given the complexity of Harriet's situation, the family physician asks for a meeting - inviting all professions to come together to discuss and prioritize the patient needs. They decide that the priority is safety and will focus on issues such as swallowing and choking, and falls prevention inside and outside the home. All of the team members will meet weekly face-to-face, with the audiologist attending via video conferencing. After approximately one month, when Harriet's health issues should be less acute, the team will only meet on an as-needed basis. Individuals on the team may consult one another outside of the team meeting.

3. Fitting-In

The collaborator shares skills and knowledge that fulfill the need identified in stage 1 (looking for help) thereby meeting the patient and team's needs. In the fitting-in stage, each team member prioritizes attending to the initial needs identified. It is understood that other team members may identify other needs, but these are not the initial priority. When fitting-in is established, it lays down a foundation of trust and respect that is felt between the team members (inclusive of the patient and family).

In the weekly meeting, the team decided that the first priority is ensuring Harriet's safety in her home. The occupational therapist, physiotherapist, dietitian, and speech-language pathologist were identified because of their knowledge and skill set to address these issues.

Continue to review how a collaborative approach was used between providers to address two safety concerns.

Home Management

The occupational therapist continues providing support for Harriet to carry out home management activities with the use of aids and energy-saving techniques hoping to remove barriers interfering with Harriet's activities. The occupational therapist also refers Harriet to Kingston Access Bus. The occupational therapist conducts a home safety assessment to determine adaptations needed in the home for Harriet and Luis to continue to live in their home.

The occupational therapist and physiotherapist **collaborate** to decide how to proceed with falls prevention education considering variables such as practitioner schedule and other treatment Harriet is receiving in her home. To address Harriet's osteoporosis the physiotherapist will assess Harriet's mobility and create a home exercise program to strengthen her lower body and trunk as well as assess Harriet's balance.

Choking

The speech-language pathologist will assess Harriet's choking experiences, assessing her ability to swallow and feed. The speech-language pathologist will also assess Harriet's experience of her voice being hoarse at times. Together, the speech-language pathologist and dietitian will work to determine a diet that will decrease the likelihood of choking.

Note: Harriet's ability to hear and utilize her hearing aids effectively was noted as a priority. Harriet attends the audiologist's office elsewhere in the city for a hearing assessment, or she may have an appointment at the primary care clinic one of the two days a month that the audiologist is on site.

It is likely that the safety concerns will be addressed through successive cycles of identifying the need, co-location (or not), and fitting-in. These cycles will:

- Address the patient's needs,
- Develop collaborative relationship-focused services, and
- Develop the interprofessional relationship between providers and the patient(s).

The team may determine that they will communicate patient progress via the EMR and/or through monthly team meetings. It is likely that informal communication strategies will be used by providers throughout the process. Informal communication might consist of a quick update by the audiologist to the speech-language pathologist in the coffee room noting that Harriet had completed her assessment, and the report was forthcoming via EMR. Or this might be an email from the physiotherapist to the occupational therapist outlining the falls prevention education, or an update about Harriet's progression through the strengthening exercise. Either way, these communication strategies will facilitate the movement through the ICRB stages.

Once the safety concerns are addressed, other needs are identified. For example, the social worker works with Harriet and Luis providing supportive counselling to help Harriet come to terms with her new reality of having osteoporosis, manage the pain, as well as perhaps the need to begin to explore options for living should the couple need more help and need to move to assisted living in the future. The social worker will also explore social, recreational, and exercise options available to Harriet and Luis in their community given their physical and financial circumstances.

4. Growing Reciprocity

Through cycles identifying needs, co-location, and fitting-in (stages 1-3), the team members begin to understand each other's health care values and the team's shared values.

When a team works together for longer periods of time, they often get to know each other on a more personal basis. This deeper understanding of one another both professionally and personally strengthens the member's trust and respect in one another. During this stage of growing reciprocity, individual team members or the collective team identify other patient needs that either a patient/family or a team member is raising. Team members in this stage value other's perspectives, appreciating their similarities, but more so appreciating their differences, perceiving them as strengths of the team. In growing reciprocity, the relationships are reciprocal, with back-and-forth information sharing and a strong sense of "we" among the team members. Finally, it is in this stage that there is a flattened hierarchy amongst team members and all team members are practicing to full scope of practice where needed.

Note: Like in real practice, not every team reaches growing reciprocity, and this is especially true when the team is large. In Harriet's case, the team has not reached this stage of development or at least it is not being exemplified here, rather each team member is working to fulfill the needs first identified. However, within a large team there may be smaller teams that do reach the growing reciprocity stage.

Interprofessional collaboration occurs when two or more professions learn about and from each other, and work to achieve common goals and improve health outcomes (WHO, 2010). As noted in the fitting-in stage, the occupational therapist and physiotherapist have previously collaborated, and over time have developed a team within the team that includes a shared treatment plan, goals, and values.

The occupational therapy/physiotherapy team has visited many patients together to do home safety and exercise assessments and they have developed trust, respect, and understanding for one another and their roles. When the occupational therapist and physiotherapist visit Harriet together, they would quickly go through stages 1-3. Assuming they are both knowledgeable and skilled professionals, they would deliver high-quality care that demonstrates growing reciprocity.

While the whole team did not reach this stage, the occupational therapy/physiotherapy team did reach reciprocity. As this large team continues to work together, the occupational therapist and physiotherapist could serve as champions and role models for other team members.

Reflection: After reflecting on Harriet, how might her care look if she were a patient in your own primary care setting? How does your current team collaborate? Would it look similar to how this team collaborated with Harriet?

Now think about Xu and Finn from the previous section. How might these patients experience team-based primary care?

In this section, you learned about how collaborative relationships are formed between team members over time using the ICRB model. You revisited the case of Harriet through the ICRB model lens. In the next section, you will be provided with additional resources for ongoing learning.

Continue to Section 1.6

Page link:

https://queensu.ca.panopto.com/Panopto/Pages/Viewer.aspx?id=eeb983f2-b79e-4e0b-acb2-b11601678caf&start=0

1.6 RESOURCES

A selection of resources have been curated to help you further your learning of team-based primary care practices.

Canada

A Vision for the Future

Continue to watch a video focusing on **Patient's Medical Home**.

Team Primary Care Projects

In collaboration with over 100 partners, over 20 practitioner-specific and over 20 team training projects are in progress to enhance, align, and increase preparedness to practice in a collaborative approach to care delivery. Supporting each of these partners are cross-cutting teams and an Indigenous Advisory Circle.

Continue to learn more about Team Primary Care Projects.

British Columbia

Pharmacists Aligned in Shared Care Teams (PACT) - Part 1 and Part 2

PACT is a new, non-accredited, multi-part learning program presented in collaboration with the Pharmacists in Primary Care Network Program. Topics include:

- **Clarifying Roles/Responsibilities:** Pharmacists will learn strategies for clarifying their roles and responsibilities, as well as those of their colleagues, to gain a better understanding of the knowledge and skills that other pharmacists have to identify opportunities for collaboration during information gathering, care provision, and follow-up.
- **Enhancing Team Functioning:** Pharmacists will learn how to work as a cohesive team, communicate to share knowledge and expertise, and work together to find solutions to complex patient cases.
- **Conflict Resolution:** Pharmacists will learn effective conflict resolution skills and strategies.
- **Collaborative Leadership and Accessing Resources:** Pharmacists will learn about the tools and resources that will facilitate collaborative patient care.

Continue to learn more about the PACT learning program.

Team Up! Team-Based Primary & Community Care in Action

This webinar and podcast series aims to connect individuals and teams, identify tools to apply to current work underway, and share experiences in team-based care across the province.

Podcasts: The Team UP! podcast explores different ideas related to team-based primary care, focusing on what is happening in British Columbia. Topics include:

- Season 1: How primary care teams work and how they can work better, together (e.g., "Relationship Centredness in Team-Based Primary Care")

- Season 2: Primary care system resilience (e.g., "Teams Can Build Resilience")
- Season 3: How to work together in distributed primary care teams (e.g., "Clearer Roles in Distributed Primary Care Teams")

Webinars: Relevant topics include:

- Relationship-Centred Care
- Getting to the How of Team-Based Care: A Dialogue Circle
- Racism in Primary Care and the In Plain Sight Report
- Cultural Safety and Humility

Continue to learn more about team-based care in British Columbia.

Ontario

Team Building Resource Guide for Family Health Teams (Part A and B)

The intent of this guide is to assist with a better understanding of some processes and finding ways to strengthen team-based care in a FHT. There are two parts to the guide, and they complement each other. Part A is an overview of teambuilding in FHTs (the current guide). Part B provides interprofessional activities to help facilitators work with FHTs to enhance team functioning.

Part A is divided into 2 sections, each of which includes a series of modules that cover important aspects that will help you develop your team's functioning and overall performance.

Section 1: Getting going – Building a Team

- Module 1: What Is an Effective Team?
- Module 2: Building a Team
- Module 3: Clarifying Roles and Expectations
- Module 4: Making the Most of Meetings
- Module 5: Evaluating Team Performance

Section 2: Improving Team Performance

- Module 6: Understanding Change
- Module 7: Enhancing Collaboration
- Module 8: Improving Communication
- Module 9: Leadership and Decision-Making
- Module 10: Conflict Management

Part B contains interprofessional activities to be used in conjunction with the corresponding Modules in Part A.

Continue to learn more about Part A of the Team Building Resource Guide for Family Health Teams.

Continue to learn more about Part B of the Team Building Resource Guide for Family Health Teams.

Interprofessional, Integrated, and Coordinated (Primary Care)

Continue a video describing how to work together as interprofessional teams to provide primary care services by working collaboratively (30 minutes).

Manitoba

Primary Care Interprofessional Team Toolkit

This toolkit builds from earlier work to help clinics in the Physician Integrated Networks to identify which providers to integrate. This version builds on this work and introduces additional resources which provide more details about each step of the process. Resources were chosen based on the questions and barriers identified by Manitoba physicians, other providers and My Health Teams.

Continue to access the Primary Care Interprofessional Team Toolkit.

Australia

Coordination of Care & Services Navigation Webinar

Continue to watch a webinar describing the key components of care coordination and how to improve coordination of care in general practice (20 minutes).

Continue to Section 1.7

Page link:

https://youtu.be/NSY_qxjP1yA?si=lFFFtQ9cUr7rnxrq

https://www.teamprimarycare.ca/projects

https://pharmacistsinpcn.ubc.ca/health-care-providers-and-pcn-administrators/health-care-providers/pharmacists-aligned-shared-care

https://teambasedcarebc.ca/

https://www.hqontario.ca/portals/0/Documents/qi/qi-rg-team-building-part-a-0901-en.pdf

https://vimeo.com/showcase/3478622/video/133174283

https://www.gov.mb.ca/health/primarycare/providers/docs/pinit.pdf

https://www.youtube.com/watch?v=v9-rdngJPpE

1.7 REFERENCES

References

- Agner, J. (2020). Moving from cultural competence to cultural humility in occupational therapy: A paradigm shift. *The American Journal of Occupational Therapy, 74*(4), 1-7. Retrieved April 2024 from https://doi.org/10.5014/ajot.2020.038067(opens in a new tab)
- Alsharif, N. Z. (2012). Cultural humility and interprofessional education and practice: A winning combination. *American Journal of Pharmaceutical Education, 76*(7), 120. Retrieved April 2024 from https://doi.org/10.5688/ajpe767120(opens in a new tab)
- Association of Family Health Teams of Ontario. (2023). *Team-based care.* Retrieved April 2024 from https://www.afhto.ca/ (opens in a new tab)
- Beagan, B. L. (2015). Approaches to culture and diversity: A critical synthesis of occupational therapy literature. *The Canadian Journal of Occupational Therapy, 82*(5), 272-282. Retrieved April 2024 from https://doi.org/10.1177/0008417414567530 (opens in a new tab)
- Bodenheimer, T., Ghorob, A., Willard-Grace, R., & Grumbach, K. (2014). The 10 building blocks of high-performing primary care. *Annals of Family Medicine, 12*(2), 166–171. Retrieved April 2024 from https://doi.org/10.1370/afm.1616(opens in a new tab)
- Canadian Interprofessional Health Collaborative. (2010, February). *CIHC National Competency Framework.* Retrieved April 2024 from https://www.cihc-cpis.com/publications1.html(opens in a new tab)
- College of Family Physicians of Canada. (2020). *Patient's medical home.* Retrieved April 2024 from https://patientsmedicalhome.ca/(opens in a new tab)
- College of Occupational Therapists of Ontario. (n.d). *Culture, equity, and justice in occupational therapy practice.* Retrieved April 2024 from https://www.coto.org/docs/default-source/culture-equity-justice/coto-culture-equity-and-justice-in-occupational-therapy-en.pdf?sfvrsn=4392a2c6_16(opens in a new tab)
- Donnelly, C., Parniak, S., Oelke, N. Rai, A., & Johnston, S. (2023). Analysis of primary health care teams and integration policy in Ontario. *Health Reform Observer - Observatoire des Réformes de Santé, 10*(4). Retrieved April 2024 from https://doi.org/10.13162/hro-ors.v10i1.4728(opens in a new tab)
- Epperly, T., Bechtel, C., Sweeney, R., Greiner, A., Grumbach, K., Schilz, J., Stream, G., & O'Connor, M. (2019). The shared principles of primary care: A multistakeholder initiative to find a common voice. *Family Medicine, 51*(2), 179–184. Retrieved April 2024 from https://doi.org/10.22454/FamMed.2019.925587(opens in a new tab)
- EQUIP Health Care. (2024). *Equipping health & social services for equity.* Retrieved April 2024 from https://equiphealthcare.ca/(opens in a new tab)
- Gerlach, A. J. (2012). A critical reflection on the concept of cultural safety. *Canadian Journal of Occupational Therapy, 79*(3), 151–158. Retrieved April 2024 from https://doi.org/10.2182/cjot.2012.79.3.4(opens in a new tab)
- Ghebreyesus, T. (2017). *Human rights day 2017.* World Health Organization. Retrieved April 2024 from https://www.who.int/news-room/commentaries/detail/health-is-a-fundamental-human-right(opens in a new tab)
- Government of Canada. (2024). *Social determinants of health and health inequalities.* Retrieved April 2024 from https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-

health.html#:~:text=Health%20equity%20seeks%20to%20reduce,conducive%20to%20health%20for%20all.(opens in a new tab)

- Government of Canada. (2022). *IRCC anti-racism strategy 2.0* (2021-2024)- Change management. Retrieved April 2024 from https://www.canada.ca/en/immigration-refugees-citizenship/corporate/mandate/anti-racism-strategy/change.html(opens in a new tab)
- Health Canada. (2015). *Primary health care.* Retrieved April 2024 from https://www.canada.ca/en/health-canada/services/primary-health-care.html(opens in a new tab)
- Hutchison, B., Levesque, J. F., Strumpf, E., & Coyle, N. (2011). Primary health care in Canada: systems in motion. *The Milbank Quarterly, 89*(2), 256-288. Retrieved April 2024 from https://doi.org/10.1111/j.1468-0009.2011.00628.x(opens in a new tab)
- Indigenous Primary Care Council. (2022). *Indigenous health systems transformation: Foundations for IPHCC's OHT provincial framework.* Retrieved April 2024 from https://iphcc.ca/wp-content/uploads/2022/09/Indigenous-HST_Booklet.pdf(opens in a new tab)
- Indigenous Primary Health Care Council. (n.d). *IPHCC vision and mission.* Retrieved April 2024 from https://iphcc.ca/iphcc-vision-mission/(opens in a new tab)
- Itchhaporia, D. (2021). The evolution of the quintuple aim: Health equity, health outcomes, and the economy. *Journal of the American College of Cardiology, 78*(22), 2262–2264. Retrieved April 2024 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8608191/(opens in a new tab)
- Jimenez, G., Matchar, D., Koh, G. C. H., Tyagi, S., van der Kleij, R. M. J. J., Chavannes, N. H., & Car, J. (2021). Revisiting the four core functions (4Cs) of primary care: Operational definitions and complexities. *Primary health care research & development, 22,* e68. Retrieved April 2024 from https://doi.org/10.1017/S1463423621000669(opens in a new tab)
- Jull, J. E., & Giles, A. R. (2012). Health equity, Aboriginal Peoples and occupational therapy. *Canadian Journal of Occupational Therapy, 79*(2), 70–76. Retrieved April 2024 from https://doi.org/10.2182/cjot.2012.79.2.2(opens in a new tab)
- Kiran, T., Tepper, J., & Gavin, F. (2020). Working with patients to improve care. *Canadian Medical Association Journal, 192*(6), E125-E127. Retrieved April 2024 from https://doi.org/10.1503/cmaj.190439(opens in a new tab)
- Klinic Community Health Centre. (2013). *Trauma-informed: The trauma toolkit (Second edition).* Retrieved April 2024 from https://med-fom-learningcircle.sites.olt.ubc.ca/files/2013/10/Trauma-informed_Toolkit.pdf(opens in a new tab)
- Lukey, A., Johnston, S., Montesanti, S., Donnelly, C., Wankah, P., Breton, M., ... & Oelke, N. D. (2021). Facilitating integration through team-based primary healthcare: a cross-case policy analysis of four Canadian provinces. *International Journal of Integrated Care, 21*(4). Retrieved April 2024 from https://pubmed.ncbi.nlm.nih.gov/34824561/(opens in a new tab)
- Marchildon, G. P., Allin, S., & Merkur, S. (2020). Canada: Health system review. *Health Systems in Transition, 22*(3), 1–194.
- Martin, D., Miller, A. P., Quesnel-Vallée, A., Caron, N. R., Vissandjée, B., & Marchildon, G. P. (2018). Canada's universal health-care system: achieving its potential. *The Lancet, 391*(10131), 1718–1735. Retrieved April 2024 from https://pubmed.ncbi.nlm.nih.gov/29483027/(opens in a new tab)
- McCarthy, D., & Klein, S. (2010, July 22). *The triple aim journey: Improving population health and patients' experience of care,* while reducing costs. The Commonwealth Fund. Retrieved April 2024 from https://www.commonwealthfund.org/publications/case-study/2010/jul/triple-aim-journey-improving-population-health-and-patients(opens in a new tab)

- National Aboriginal Health Organization. (2008). *Cultural competency and safety: A guide for health care administrators, providers, and educators.* National Aboriginal Health Organization.
- National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Implementing High-Quality Primary Care; Robinson, S. K., Meisnere, M., Robert L. Phillips, J., & McCauley, L. (Eds.). (2021). Summary. In *Implementing high-quality primary care: Rebuilding the foundation of health care.* Washington (DC): National Academies Press (US). Retrieved April 2024 from https://www.ncbi.nlm.nih.gov/books/NBK571800/(opens in a new tab)
- Nixon, S. A. (2019). The coin model of privilege and critical allyship: Implications for health. *BMC Public Health, 19*(1), 1637. Retrieved November 2023 from https://doi.org/10.1186/s12889-019-7884-9
- OECD. (2020). Realising the potential of primary health care. *OECD Publishing.* Retrieved April 2024 from https://doi.org/10.1787/a92adee4-en.(opens in a new tab)
- Starfield, B., Shi, L., & Macinko, J. (2005). Contribution of primary care to health systems and health. *The Milbank Quarterly, 83*(3), 457–502. Retrieved April 2024 from https://doi.org/10.1111/j.1468-0009.2005.00409.x(opens in a new tab)
- Van der Kolk, B. A. (2015). *The body keeps the score: Brain, mind, and body in the healing of trauma.* Penguin Books.
- Wallace, P., & Seidman, J. (2007). Improving population health and chronic disease management. In J. Dorland & M. A. McColl (Eds.), *Emerging approaches to chronic disease management in primary health care* (pp. 15–20). Queen's Policy Studies.
- Wener, P., & Woodgate, R. L. (2016). Collaborating in the context of co-location: A grounded theory study. *BMC Family Practice, 17*, 30. Retrieved April 2024 from https://pubmed.ncbi.nlm.nih.gov/26965307/(opens in a new tab)
- World Health Organization. (2021). *It's time to build a fairer, healthier world for everyone, everywhere: Health equity and its determinants.* Retrieved April 2024 from https://cdn.who.int/media/docs/default-source/world-health-day-2021/health-equity-and-its-determinants.pdf?sfvrsn=6c36f0a5_1&download=true(opens in a new tab)
- World Health Organization. (n.d.). *Primary care.* Retrieved April 2024 from https://www.who.int/teams/integrated-health-services/clinical-services-and-systems/primary-care

Continue to Section 1.8

1.8 ACKNOWLEDGEMENTS

Acknowledgements

This module was led by Catherine Donnelly and Nicole Bobbette from Queen's University with contributions from:

- Rachelle Ashcroft, University of Toronto
- Sheila Moodie, Western University
- Jordan Miller, Queen's University
- Keith Adamson, University of Toronto
- Mary Anne Smith, Dietitians of Canada
- Jennifer Cameron-Turley, Speech-Language & Audiology Canada
- Anne Carey, Speech-Language & Audiology Canada
- Andrew Freeman, Université Laval
- Lori Letts, McMaster University
- Pamela Wener, University of Manitoba
- Leanne Leclair, University of Manitoba
- Cara Brown, University of Manitoba
- Lisa Diamond-Burchuk, University of Manitoba
- Kaarina Valavaara, Dalhousie University
- Carri Hand, Western University
- Hélène Sabourin, Canadian Association of Occupational Therapists
- Josée Seguin, Canadian Association of Occupational Therapists

Special thanks to: Shannon Jones, Project Manager

This module was created in collaboration with the Course Development team in the Office of Professional Development and Educational Scholarship, Faculty of Health Sciences, Queen's University.

This project also acknowledges the Canadian Association of Occupational Therapists as a partner organization.

Funding Acknowledgement

This project is one of a number of projects funded through Team Primary Care – Training for Transformation. Team Primary Care is an interprofessional initiative of the Foundation for Advancing Family Medicine funded by the Government of Canada's Employment and Social Development Canada program. It is co-led by the College of Family Physicians of Canada and the Canadian Health Workforce Network, in partnership with over 100 health professional and educational organizations across Canada.